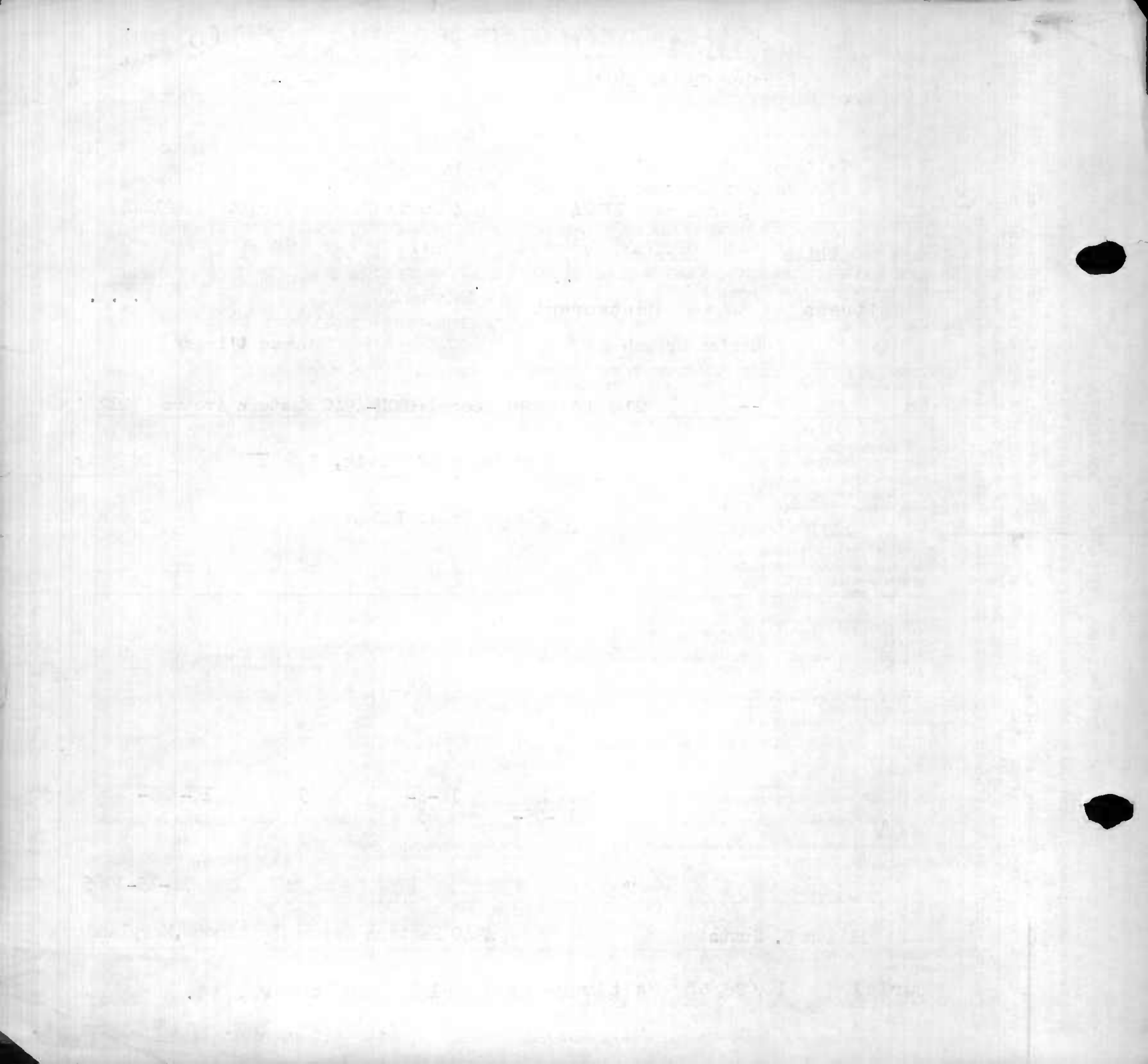


## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-30		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11001	
M.E. CASE NO.		65 11001		Certificate of Death	
1. NAME OF DECEASED (Type or Print)		Bernice Crouch Smith		2. DATE AND HOUR OF DEATH 10-25-1965 4 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 23-01	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 914 South Charles Street		21224	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1914	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Crouch		14. MOTHER'S MAIDEN NAME Grace O'Leary	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 218 14 6329		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of Cervix, I C III DUE TO (B) Urinary Tract Infection DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years 1 + months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-6-1965 to 10-25-1965, that (I) (we) last saw the deceased alive on 10-25-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William B. Cutts		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-25-1965	
23C. PHYSICIAN'S NAME (Type) William B. Cutts		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/28/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 27 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 Light St.			

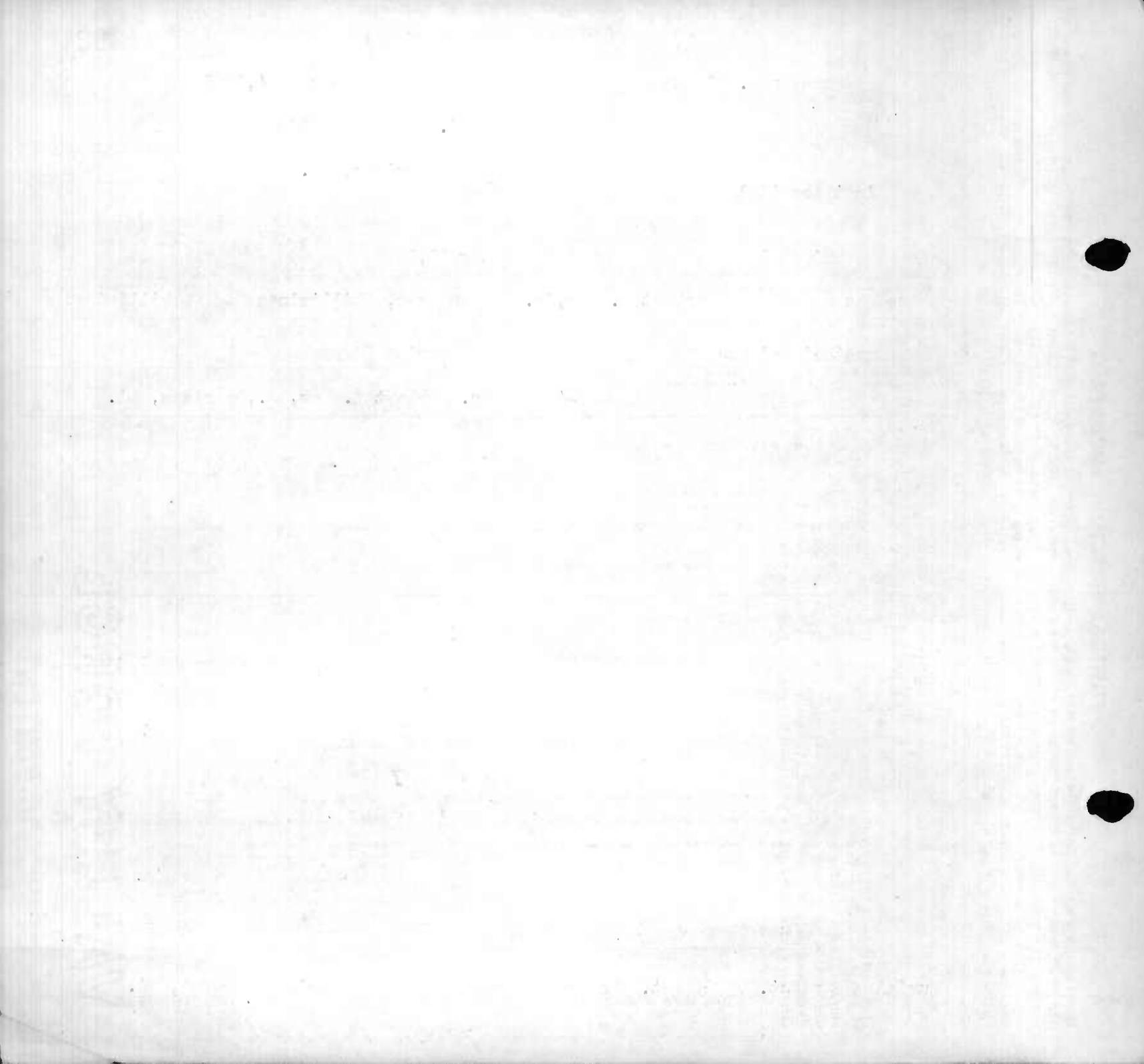




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.5em;">65 11002</span>	
BIRTH NO. <span style="font-size: 1.5em;">65 11002</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Bernabe E. Albeza</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 4, 1965</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">Sinai Hospital</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Garrison, Md.</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">53-00</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Oriental</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Never married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">May 13, 1897</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">68</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Houseman</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Herbert A. May, jr.</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">San Jose, Phillipines</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">Phillipines</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Anastacio Albeza</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Juanita Edrama</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">219-07-4755A</span>	17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Herbert A. May, Jr., Garrison, Md.</span>		
18. <span style="font-size: 1.5em;">420.01</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <span style="font-size: 1.2em;">arteriosclerotic heart disease</span> (B) (C)  INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">few years</span>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">14 Apr</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">Sept 29</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Paul H Royse</span>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">6 Oct 65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Paul H Royse</span>		23D. ADDRESS M.D. <span style="font-size: 1.2em;">1403 Foley La. Pikesville 8 Md.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">Oct. 7, 1965</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">St. Thomas Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Garrison Forrest, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 27 1965</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Bernabe E. Albeza</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Frank H. Newell, Pikesville 8 Md.</span>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>65-18974</u> <u>65 11003</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 11003</u>	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) <u>SILL, JENNIFER LYNNE</u>				<u>8-8-65</u>		<u>11:57P M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE <u>MARYLAND</u>		B. COUNTY <u>Balto</u>	
<u>ST. AGNES HOSPITAL</u> <u>BALTIMORE, MARYLAND 21229</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<u>BALTIMORE</u>	
D. STREET ADDRESS (If rural, give location)				<u>7311 CASTLEMOOR ROAD</u>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
<u>FEMALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>7-31-65</u>		<u>8</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>BABY</u>				<u>MARYLAND</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>CHARLES SILL</u>				<u>MARTHA KOHOUT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
<u>NO</u>				<u>ST. AGNES HOSPITAL RECORDS BALTO.29</u>			
18. <u>754.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <u>Acute heart failure</u>		<u>12 hrs -</u>	
				(B) <u>Congenital heart disease - 1-8 Transposition of aorta</u>		<u>7 days</u>	
				(C) <u>2 - Pulmonary stenosis</u> <u>3 - Interventricular septal defect</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-8-65</u> 19 <u>8-8-65</u> 19 <u>8-8-65</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8-8-</u> 19 <u>65</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
23A. SIGNATURE <u>Luningning M. Aldaba</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <u>8-9-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>LUNINGNING M. ALDABA</u> M.D.				23D. ADDRESS <u>ST. AGNES HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Cremation Aug 10, 1965 Greenmount Crematory</u>				<u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 27 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Frank H. Newell, Pikeville, Md.</u>		ADDRESS	

100-10101-101

100-10101-101

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100-10101-101

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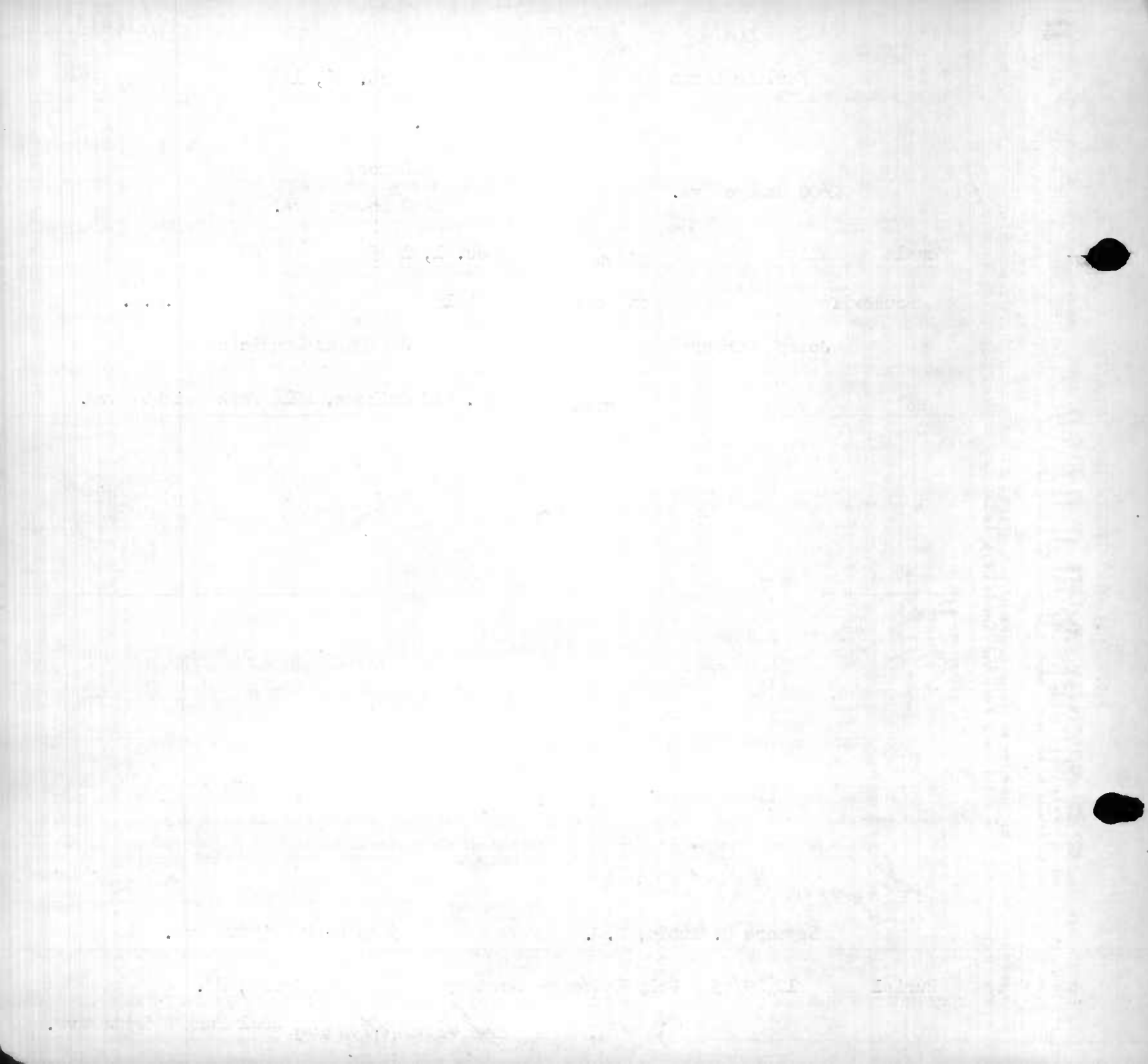
100-10101-101

100-10101-101

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11004		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11004	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Pauline Renda		2. DATE AND HOUR OF DEATH Oct. 26, 1965 4 18 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION 2600 Oswego Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 15-13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2600 Oswego Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Dec. 1, 1895	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Barbera			14. MOTHER'S MAIDEN NAME Josephine Laudicina		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS Mrs. Alf Eriksen, 4216 Park Heights Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) congestive heart failure DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 day Several years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1964 to Oct 26 1965, that (I) (we) last saw the deceased alive on Oct 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Seymore H. Rubin, M.D.				23B. DATE SIGNED 10/26/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 5415 Park Heights Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/29/65		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. STATE (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. OCT 27 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Vernon L. Leman	
25D. ADDRESS 4611 Park Heights Ave.					





## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Clarence Robert Evans

2. DATE AND HOUR OF DEATH

10-24-1965

9:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

**CERTIFICATE AMENDED**FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

11-3-65

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

(Rural)

D. STREET ADDRESS (If rural, give location)

1818 Forrest Road

21219

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5-18-1900

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Patapsco Back Rivers R.R.

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alfred

MOTHER'S MAIDEN NAME

Elizabeth

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocardial Infarction

2 hours

DUE TO

Generalized Atherosclerosis

years

(B) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Congestive Heart Failure

4 days

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At  
WorkNot While  
At Work22. I certify that (I) (this hospital) attended the deceased from 10-22-19 65 to 10-24-19 65,  
that (I) (we) last saw the deceased alive on 10-24-19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John R. Burton

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys. ☒

23B. DATE SIGNED

10-24-1965

23C. PHYSICIAN'S  
NAME (Type)

John R. Burton

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

OCT 27 1965

Robert E. Taylor

Cornell Funeral Home - 300 Mac Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153

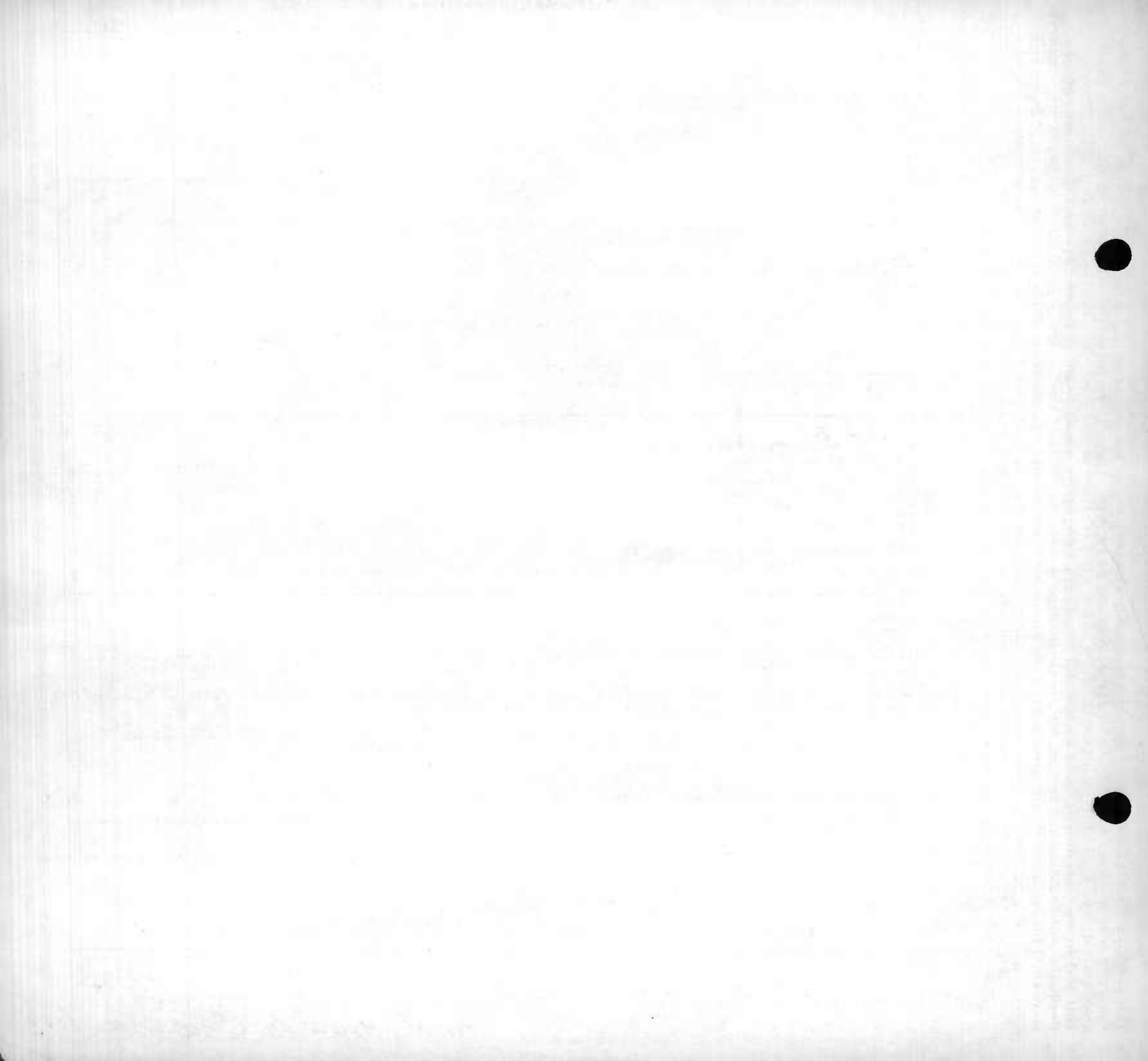
11-3-65

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11006	
BIRTH NO. 65 11006		CERTIFICATE OF DEATH		Registered No. 65 11006	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Thompson, Grace Marie		2. DATE AND HOUR OF DEATH 11:50 AM Oct 25, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		A. STATE Md. B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1 N. Stuart St			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7/5/08	9. AGE (In years last birthday) 56	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME IRA COVER		14. MOTHER'S MAIDEN NAME Alice Warner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Self	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410X1		CAUSE OF DEATH (A) DUE TO RHD & AI, MS, MI CHF (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 40 years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Electrolyte Imbalance					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/18 19 65 to 10/25 19 65, that (I) (we) last saw the deceased alive on 10/25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph Gardner		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/25/65	
23C. PHYSICIAN'S NAME (Type) RALPH GARDNER		23D. ADDRESS 3002 ST. PAUL ST., BALTO. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Oct. 28-65	24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 27 1965	25B. NAME OF REGISTRAR Robert E. Fairbank	25C. FUNERAL DIRECTOR Annally Funeral Home		ADDRESS 300 Grace Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11007		CERTIFICATE OF DEATH		Registered No. 11007	
1. NAME OF DECEASED (Type or Print) <b>JOHN VANBUREN ROBERTSON</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 20, 1965</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY OF MD. HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>13-07</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3913 ROLAND AVENUE</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>W.</b>	8. DATE OF BIRTH <b>9/21/98</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watch maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Watch Repairing</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>CHARLES ROBERTSON</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA J. HERRER</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			
16. SOCIAL SECURITY NO. <b>220 05 7511</b>			17. INFORMANT <b>medical record</b>			ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>451X I</b> <b>Pneumonia</b>				CAUSE OF DEATH (A) DUE TO <b>Abdominal aortic aneurysm</b> (B) DUE TO <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>2 yrs.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>10/16/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abd. aortic aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or out of home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR?		(If Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>9/14/65</b> to <b>10/20/65</b> that (I) (we) last saw the deceased alive on <b>10/20/65</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Carl F. Berner</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/20/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>CARL F. BERNER</b>				23D. ADDRESS <b>University Hospital Balto Md</b>					
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>25 Oct 65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md / PK Mt. View Rd</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Burger Funeral Home 3631 Falls Rd Balto Md</b>					

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

1913

CHICAGO, ILL.

RECEIVED

W.V. 1

CHICAGO, ILL.

1913

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11008		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11008	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>CLARENCE Blueford</i>		2. DATE AND HOUR OF DEATH <i>10/26/65 3:15 A. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2303</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>13 J.B.S.A.</i>		D. STREET ADDRESS (If rural, give location) <i>1772 S. HARVARD ST</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>10-25-21</i>	9. AGE (In years last birthday) <i>44</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Va Baker</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Roland</i>		14. MOTHER'S MAIDEN NAME <i>Alice King</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO. <i>213-16-5378</i>		17. INFORMANT <i>Family - Jane</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>162.1 I</i>		CAUSE OF DEATH (A) <i>Bronchogenic Carcinoma</i> DUE TO (B) <i>with cerebral metastases</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/23/65</i> to <i>10/26/65</i> , that (I) (we) last saw the deceased alive on <i>10/26/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Calvin E. Jones, Jr.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/26/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>South Baltimore General Hosp</i>		23D. ADDRESS <i>1213 Light St. Balto, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>13</i>		24B. DATE <i>10/29/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Balto Har</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 27 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>	
25C. FUNERAL DIRECTOR <i>W. C. Colly</i>		ADDRESS <i>130 E. Ford St</i>			



1  
H-500

65 11009

BALTIMORE CITY HEALTH DEPARTMENT

65 11009

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ARTHUR HAHN (JOHN)

2. DATE AND HOUR PRONOUNCED DEAD 10/25/65 5:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2102

D. STREET ADDRESS (If rural, give location) 868 Washington Blvd.

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital

5. SEX male

6. RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced

8. DATE OF BIRTH 6-27-1910

9. AGE (In years last birthday) 55

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic

11. BIRTHPLACE (State or foreign country) Balto

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Hahn

14. MOTHER'S MAIDEN NAME Florence Schultz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) Yes WWII

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 10/26/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 10/29/65

23C. NAME OF CEMETERY or CREMATORY Balto Natural

23D. LOCATION (City, town, or county) Balto

24A. DATE REC'D BY HEALTH DEPT. OCT 27 1965

24B. NAME OF REGISTRAR Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR John J. Couran

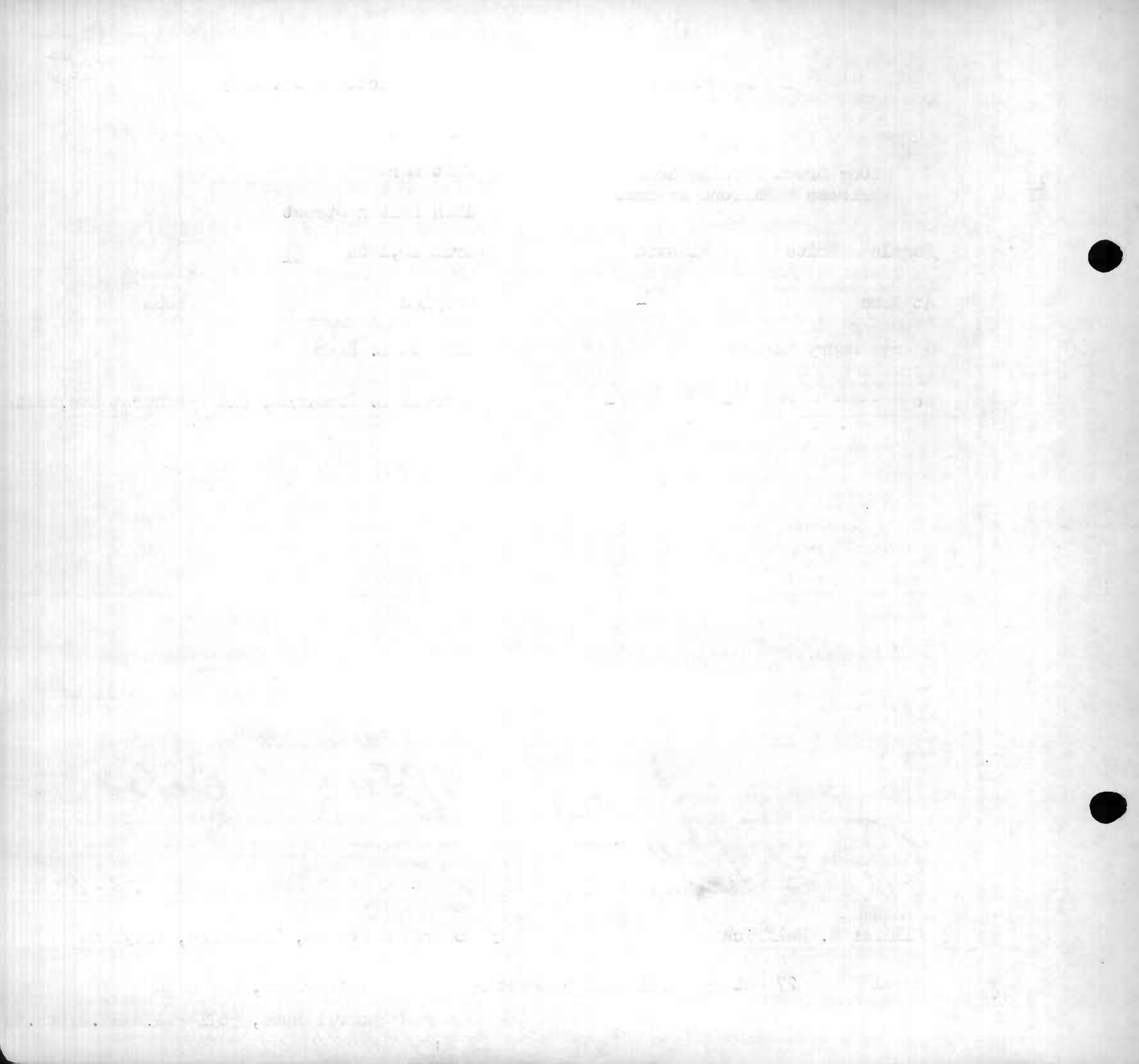
24D. ADDRESS Balto Md.

VALLEY POLICE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11010	
BIRTH NO. 65 11010		CERTIFICATE OF DEATH		Registered No. 65 11010	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) IDA MAE SIMMONDS		2. DATE AND HOUR OF DEATH October 24, 1965 1705 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		B. COUNTY Baltimore	
Long Green Nursing Home Melrose & Bellona Avenues		D. STREET ADDRESS (If rural, give location)		1224 Bolton Street	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH April 10, 1884	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Henry Wagner		14. MOTHER'S MAIDEN NAME Annetta L. Hood	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS Carroll L. Simmonds, 618 Wyndhurst Ave, Balto.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		1950 19 to Oct 24 19 65			
23A. SIGNATURE William G. Helfrich		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10-26-65	
23C. PHYSICIAN'S NAME (Type) William G. Helfrich		23D. ADDRESS M.D. 5006 Roland Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 27 Oct 65		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Maryland		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 27 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Burgee Funeral Home, 3631 Falls Rd. Balto. Md. By: [Signature]	

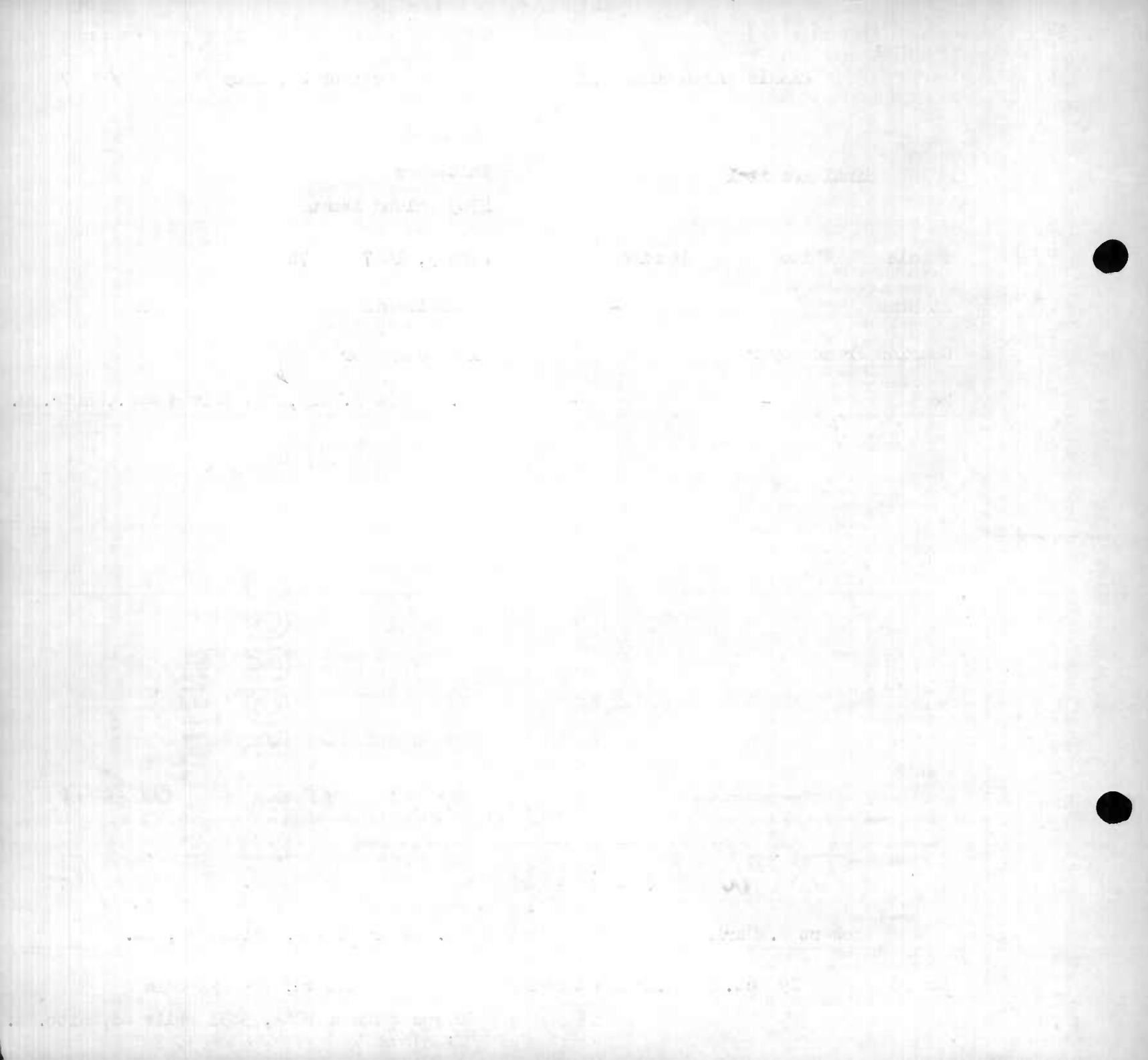




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <b>65 11011</b>		CERTIFICATE OF DEATH		Registered No. <b>65 11011</b>	
1. NAME OF DECEASED (Type or Print) <b>JENNIE MABEL BOYER ELY</b>				2. DATE AND HOUR OF DEATH <b>October 26, 1965</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-14</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>4703 Roland Avenue</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>June 3, 1887</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Frank Boyer</b>				14. MOTHER'S MAIDEN NAME <b>Alda Schaeffer</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Rev. George K. Ely, 4703 Roland Ave., Balto. Md.</b>				ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Coronary Arteriosclerotic Heart Dis</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs ±</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 13 1965</b> to <b>Oct 26 1965</b> , that (I) (we) last saw the deceased alive on <b>Oct. 21 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Robert W. Garis</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/26/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Robert W. Garis</b>				23D. ADDRESS M.D. <b>12 E. Eager Street, Baltimore, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>29 Oct. 65</b>		24C. NAME of CEMETERY or CREMATORY <b>Fairview Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Kutztown, Pennsylvania</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Garis</b>		25C. FUNERAL DIRECTOR <b>Burges Funeral Home, 3631 Falls Rd, Balto. Md.</b>		ADDRESS <b>By: Walter Burges Jr</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 11012	
65 11012					
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mary Jean Mehling		3:15 AM 10/22/65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.			
University Hospital		B. COUNTY 15-06			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Balto. 34			
		D. STREET ADDRESS (If rural, give location)			
		1863 Edgewood Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	Married	9/15/31	34	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House wife				Iowa	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Robert Kern		Alma Olson		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				R. Stoner, M.D. University Hospital	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Starvation		Months	
ANTECEDENT CAUSES		Depression Reaction		<del>Months</del> 9 Years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) Stating the UNDERLYING CONDITION last.		Released by medical examiner on approval by Dr. Graham		F. K. Miller	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/21 1965 to 10/22 1965, that (I) (we) last saw the deceased alive on 10/22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Robert E. Stoner, M.D.		10/22/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Robert E. Stoner, M.D.		University Hospital Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10/26/65		Ornuid Ridge Cemetery	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 27 1965		Robert E. Stoner		Eugenia K. Seitz 5209 York Rd Balto. Md.	

University Hospital  
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Examination Report

12/15/15

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>11013</u>				
BIRTH NO. <u>11013</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Henry Lupo (Henry J. Lupo)</u>					2. DATE AND HOUR OF DEATH <u>10-22-65</u> <u>3:00 p.m.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>203</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1617 Lancaster Street</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>7-30-26</u>	9. AGE (In years last birthday) <u>39</u>	If Under 1 Yr. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			
13. FATHER'S NAME <u>Kasmere Lupo (Kaziemierz Lupo)</u>					14. MOTHER'S MAIDEN NAME <u>Stecela Gurecka (Stanislaw Gurecka)</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-18-9172</u>		17. INFORMANT ADDRESS <u>Alfreda Osiecki 3011 1/2 3rd. Avenue #34</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Alcohol withdrawal syndrome 7 days</u>					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Malnutrition; gram negative sepsis</u>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>10/15/65</u> to <u>10/22/65</u> and that (I) (we) last saw the deceased alive on <u>10/22/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Lee J. Silver</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>10/22/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lee J. Silver</u>					23D. ADDRESS M.D. <u>Johns Hopkins Hospital, Balto</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-26-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Rosary Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>7301 German Hill Rd. Balto, 22, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 27 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Farkema</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Charles L. Gailer 901 S. Conkling St. #24</u>			

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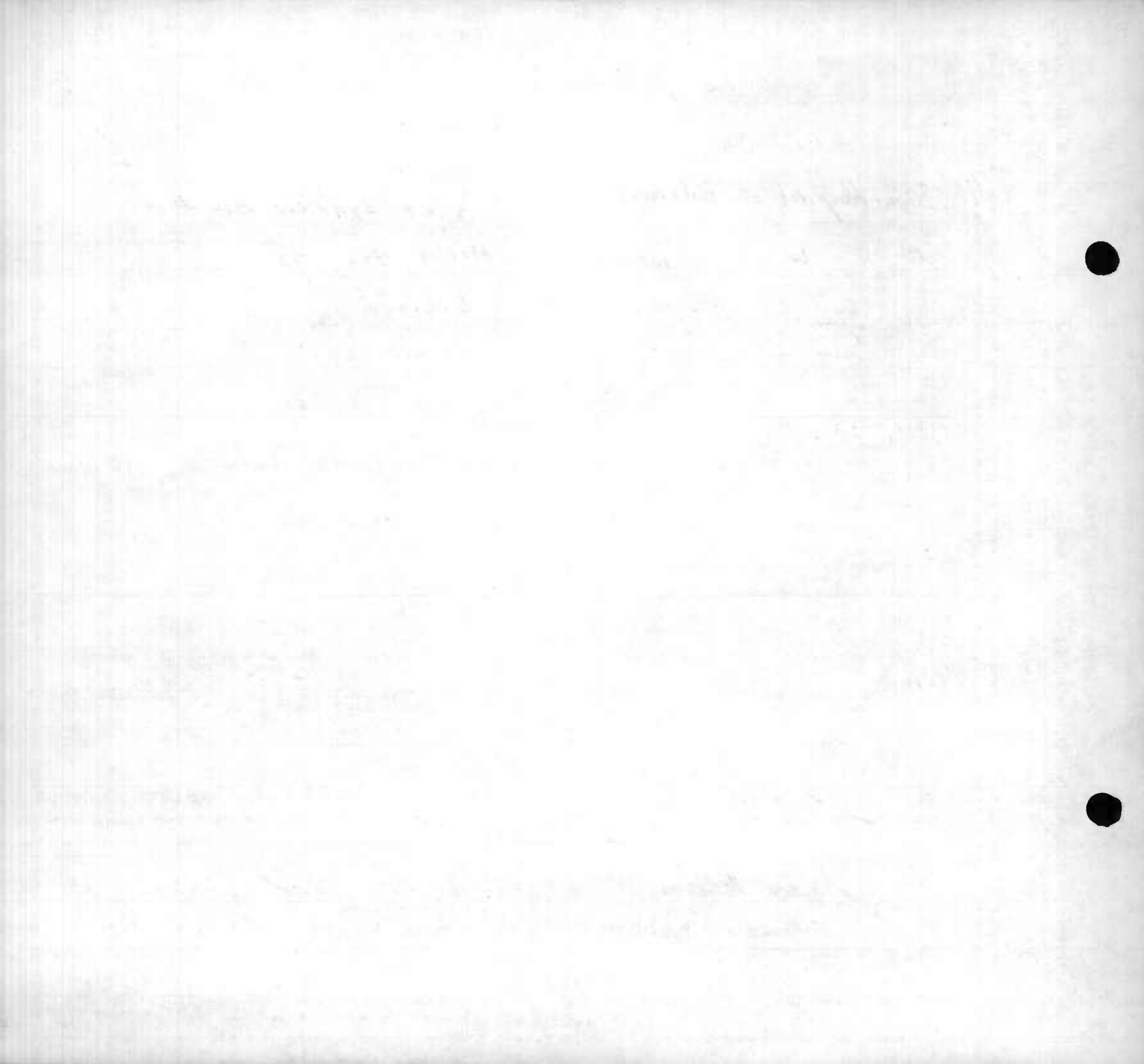
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 11014		65 11014		65 11014	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Kuranitz, Nathan</i>			2. DATE AND HOUR OF DEATH <i>26 Oct 65</i> <i>8:00 A</i> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i>			A. STATE <i>Maryland</i> B. COUNTY <i>28-31</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>5304 Lynview Ave #15</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>May 18, 1892</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self Employed</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>CIGAR</i>		11. BIRTHPLACE (State or foreign country) <i>ENGLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Simon</i>		14. MOTHER'S MAIDEN NAME <i>GOLDIE</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>215-09-1890</i>		17. INFORMANT ADDRESS <i>Hospt RECORDS</i>	
18. CAUSE OF DEATH					
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i>					
18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic Cardiovascular Disease</i>					
18C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>we</i> (this hospital) attended the deceased from <i>25 Oct</i> 19 <i>65</i> to <i>26 Oct</i> 19 <i>65</i> , that (I) <i>we</i> last saw the deceased alive on <i>26 Oct</i> 19 <i>65</i> and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Solomon Robbins</i> M.D.				23B. DATE SIGNED <i>26 Oct 65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Solomon Robbins</i> M.D.				23D. ADDRESS <i>Sinai Hospital, Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10/27/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>SOUTHERN AVE</i>	
24D. LOCATION <i>BALTO</i>		(City, town, or county)		(State) <i>MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 27 1965</i>		25B. NAME OF REGISTRAR <i>R. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>SYLVAN S. LEWIS &amp; SON, INC - 3319 OLYMPIA AVE</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11015				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11015	
1. NAME OF DECEASED (Type or Print) <b>SOJKA PAUL P.</b>				2. DATE AND HOUR OF DEATH <b>23<sup>rd</sup> October '65. 6:15 AM.</b>		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>MERCY HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>S.E. G.B.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>GLEN BURNIE 21061 52-00</b>			
				D. STREET ADDRESS (If rural, give location) <b>619 GREENWAY</b>					
5. SEX <b>M.</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>JUNE 29, 91</b>	9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>self employed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BAR+LOUNGE</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>american</b>			
13. FATHER'S NAME <b>JOHN SOJKA</b>				14. MOTHER'S MAIDEN NAME <b>AGNES SOJOKA</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-32-2848</b>		17. INFORMANT <b>HOSPITAL RECORD</b>		ADDRESS			
18. <b>15 OX I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma of esophagus</b>				(A) DUE TO		(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/16/65</b> 19 to <b>10/23</b> 19 <b>65</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>10/22</b> 19 <b>65</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.									
23A. SIGNATURE <b>Maria Pia Caldini</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/23/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>MARIA PIA CALDINI</b>				23D. ADDRESS <b>MERCY HOSP. HOUSE ST</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/27/65</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>W. Ziolkowski</b>		25D. ADDRESS <b>2007 Eastern Ave. Balto md 21231</b>			

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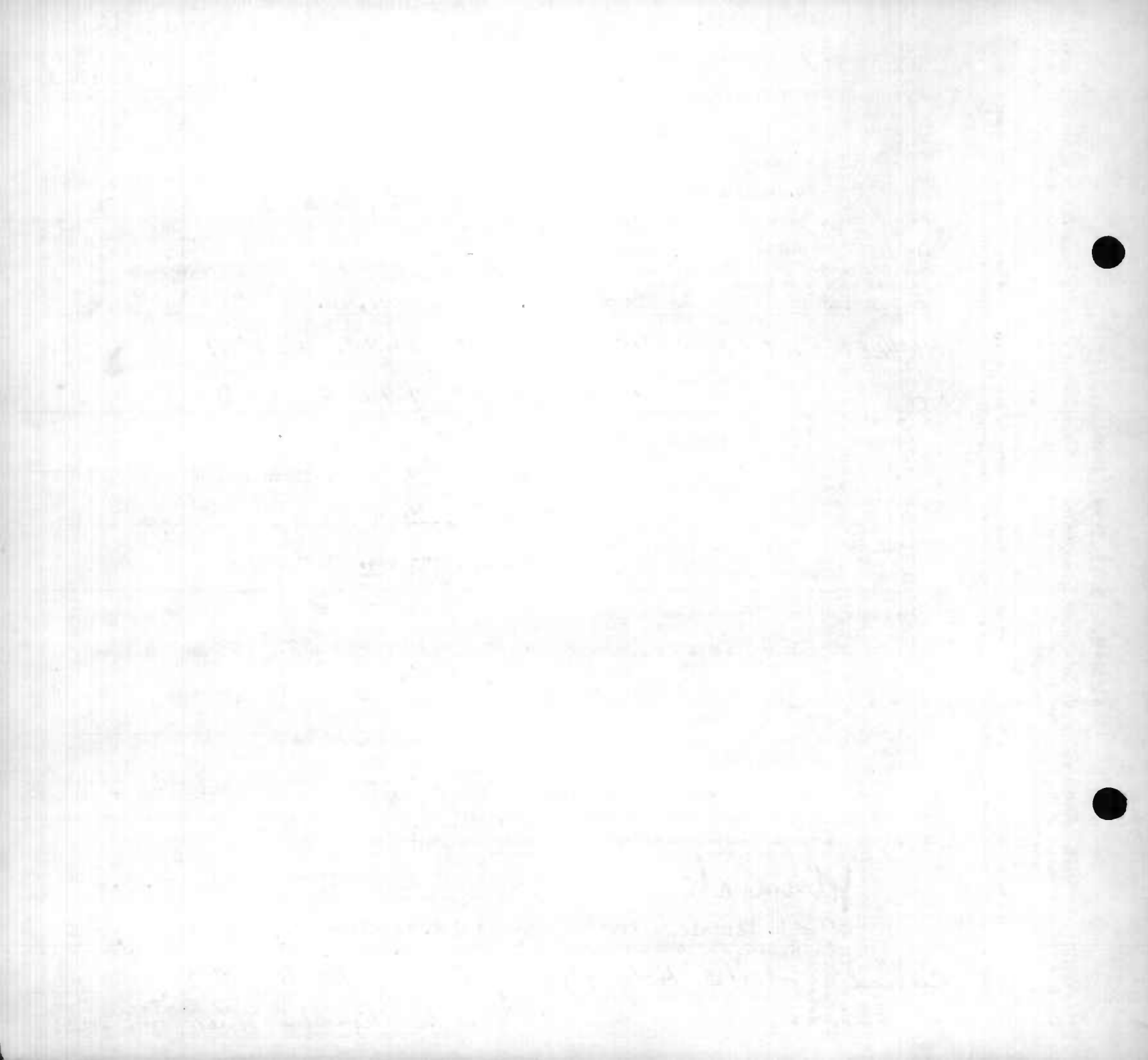
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 11016</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11016</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>WOJCIECHOWSKI, SAMUEL</b>		<b>October 25, 1965</b>		<b>6:20 A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>St. Joseph Hospital</b>		A. STATE <b>Maryland</b>			
		B. COUNTY <b>21037 94</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Edgewater,</b>			
		D. STREET ADDRESS (If rural, give location) <b>Box 9018, Route # 3</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7-18-08</b>	9. AGE (in years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ILA STA of Balto.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>MICHAEL WOJCIECHOWSKI</b>			14. MOTHER'S MAIDEN NAME <b>JOSEPHINE KLICH</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-1167</b>		17. INFORMANT ADDRESS <b>HOSPITAL RECORD</b>	
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Coronary occlusion</b> DUE TO <b>arteriosclerotic cardiovascular disease</b> (B) <b>Diabetes mellitus</b> DUE TO (C) <b>Gangrene, 4th toe, right foot.</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 8, 1965</b> to <b>October 25, 1965</b> , that (I) (we) last saw the deceased alive on <b>October 25, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. D. Mannalo</b>				23B. DATE SIGNED <b>Oct. 25, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose D. Mannalo,</b>				23D. ADDRESS M.D. <b>1400 N. Caroline St., Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/28/65</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto - MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jankowski</b>		25C. FUNERAL DIRECTOR ADDRESS <b>W. Fialkowski 2007 Eastern Ave. Balto. MD. 21231</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

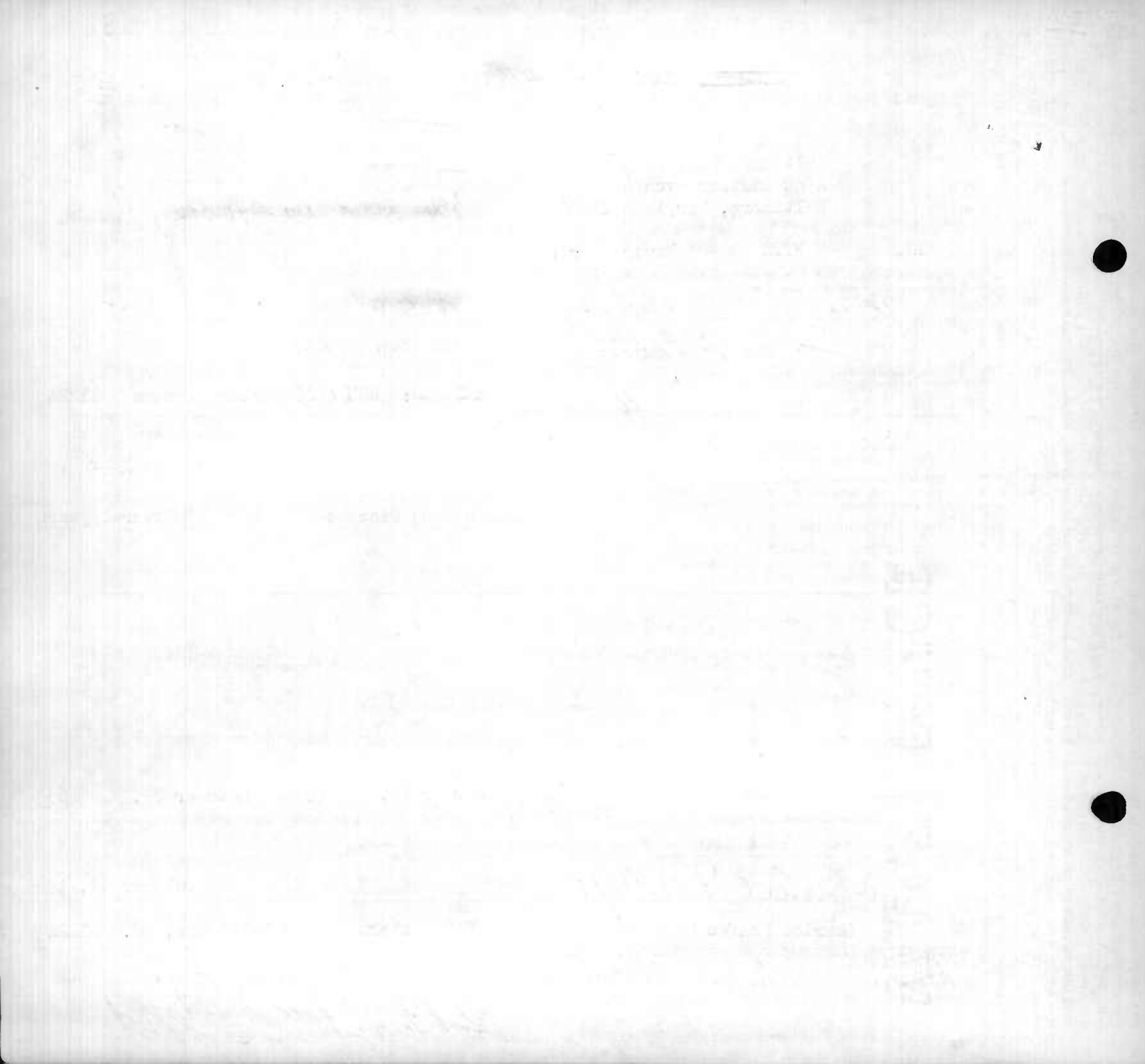
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11017</b>	
BIRTH NO. <b>65 11017</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MICHAEL TUTIN</b>		2. DATE AND HOUR OF DEATH <b>10 AM 10/23/65</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1-04</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>2112 CAMBRIDGE ST.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>			
		D. STREET ADDRESS (If rural, give location) <b>2112 CAMBRIDGE ST.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-18-88</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>POLAND</b>		13. FATHER'S NAME <b>NOT KNOWN</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>168-14-2910</b>		17. INFORMANT <b>C. TUTIN</b> ADDRESS <b>2112 CAMBRIDGE ST. BALTO. MD. 21231</b>	
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIO SCLEROTIC DISEASE</b>		CAUSE OF DEATH (A) <b>HEART</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 25 19 65</b> to <b>10/23 19 65</b> , that (I) (we) last saw the deceased alive on <b>10/13 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Irvin B. Kaplan</b>				23B. DATE SIGNED <b>10/25/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Irvin B. Kaplan</b>		23D. ADDRESS <b>129 S. BROADWAY BALTO 31 MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/27/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>St Stanislaus Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR <b>W. A. Ziolkowski</b> ADDRESS <b>2007 Eastern Ave. BALTO MD 21231</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11018				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11018	
1. NAME OF DECEASED (Type or Print) <del>William</del> <b>FLATOW</b>				2. DATE AND HOUR OF DEATH October 23, 1965				3:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>KROG</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>636 Lenoir Ave Miami, Florida</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>5/18/89</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>clothing</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Flatow</b>				14. MOTHER'S MAIDEN NAME <b>Eva (Hendelsohn)</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT ADDRESS <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>			
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Carcinoma of lung</b> DUE TO (B) <b>Chronic Lung Disease</b> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>One year</b> <b>Several years</b>									
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>October 19, 1965</b> to <b>October 23, 1965</b> , that (I) (we) lost saw the deceased alive on <b>October 23, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Laurice McAfee</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>October 23, 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>Laurice McAfee</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Md. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>10/24/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Miami, Fla</b>		24D. LOCATION (City, town, or county) (State) <b>Miami, Fla</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>6010 Rust Rd</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11019	
BIRTH NO. M.E. CASE NO.		65 11019		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
LILIAN FINK			10/23/65 4 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)  2507 PINEBRUSH ROAD			A. STATE MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 2507 PINEBRUSH ROAD		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SOLOMON FINK			14. MOTHER'S MAIDEN NAME CELICLIA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MRS. HELEN PIFFERLING 2507 PINEBRUSH RD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) acute myocardial Infarct DUE TO (B) Arterio-sclerotic Heart Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Immediate
			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none -		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		-	No	-	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
-					
22. I certify that (I) (this hospital) attended the deceased from 10/18 1965 to 10/23 1965, that (II) (we) last saw the deceased alive on 10/22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. J. Ellin			23B. DATE SIGNED 10/23/65		
23C. PHYSICIAN'S NAME (Type) M. J. Ellin			23D. ADDRESS 8629 Liberty Rd. Randallstown, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 10/25/65	24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 27 1965		25B. NAME OF REGISTRAR R. E. Farley		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	

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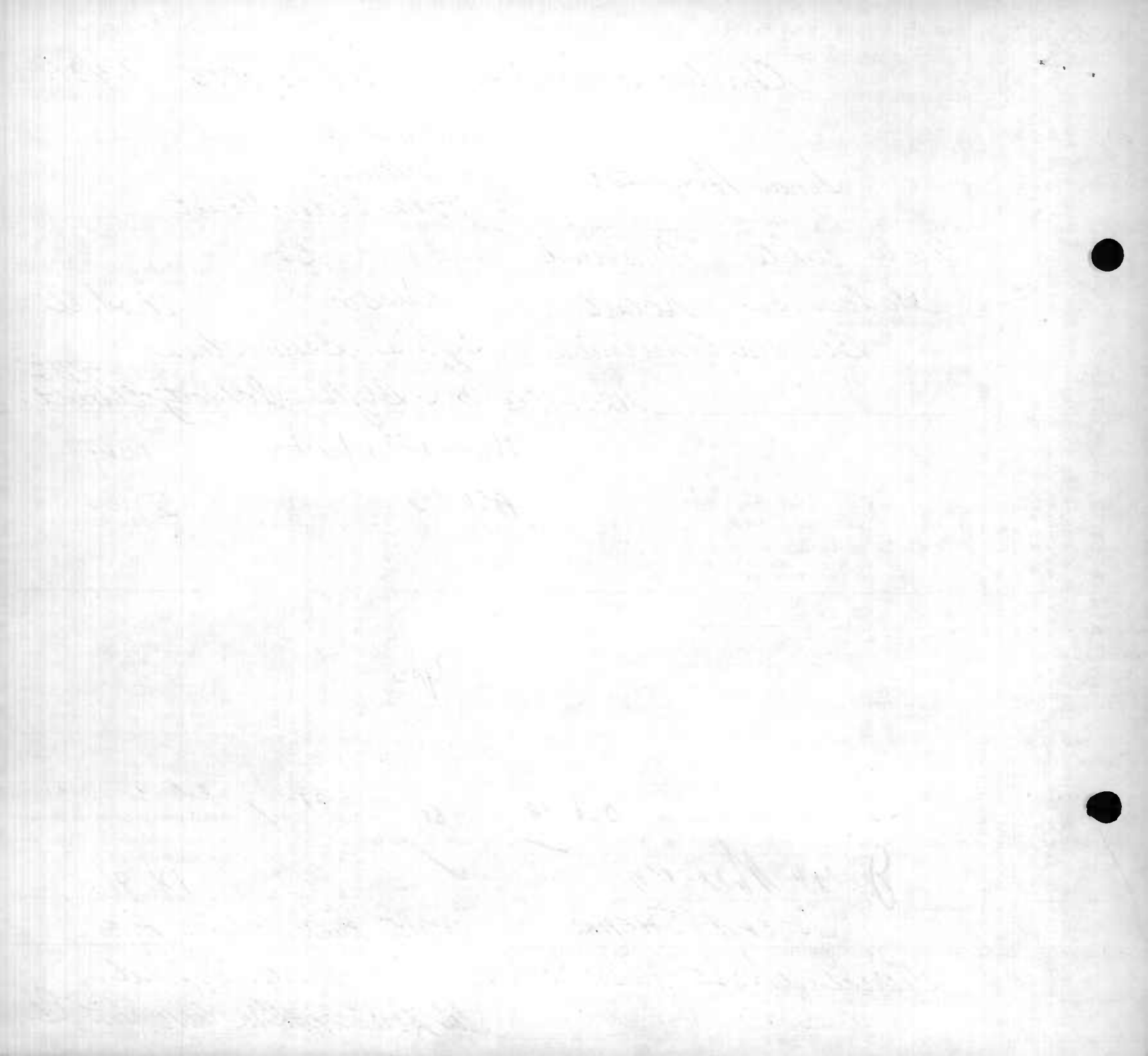
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 11020		CERTIFICATE OF DEATH				Registered No. 65 11020			
M.E. CASE NO.		1. NAME OF DECEASED <i>Charles Amernick</i>				2. DATE AND HOUR OF DEATH <i>Oct. 18, 1965 9:40 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital</i>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>7412 Eldon Court</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>August 8, 1909</i>	9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retail</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>Bernard Amernick</i>				14. MOTHER'S MAIDEN NAME <i>Sylvia Brownstein</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-01-7833</i>		17. INFORMANT <i>Mrs. Brylene Schwartz-Eldon Ct.</i>		ADDRESS <i>7412</i>			
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <i>Myocardial infarction</i> <i>ASCVD</i> (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 years</i>	
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION <i>2</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>1959</i> to <i>Oct 18</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Oct 18</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Joseph Shear</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10/19/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSEPH SHEAR</i>				23D. ADDRESS <i>6715 PARK HEIGHTS AVE.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/20/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Trinko Rodosh</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 27 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>St. Leonard Bros.</i>		ADDRESS <i>6000 Rust Rd.</i>			

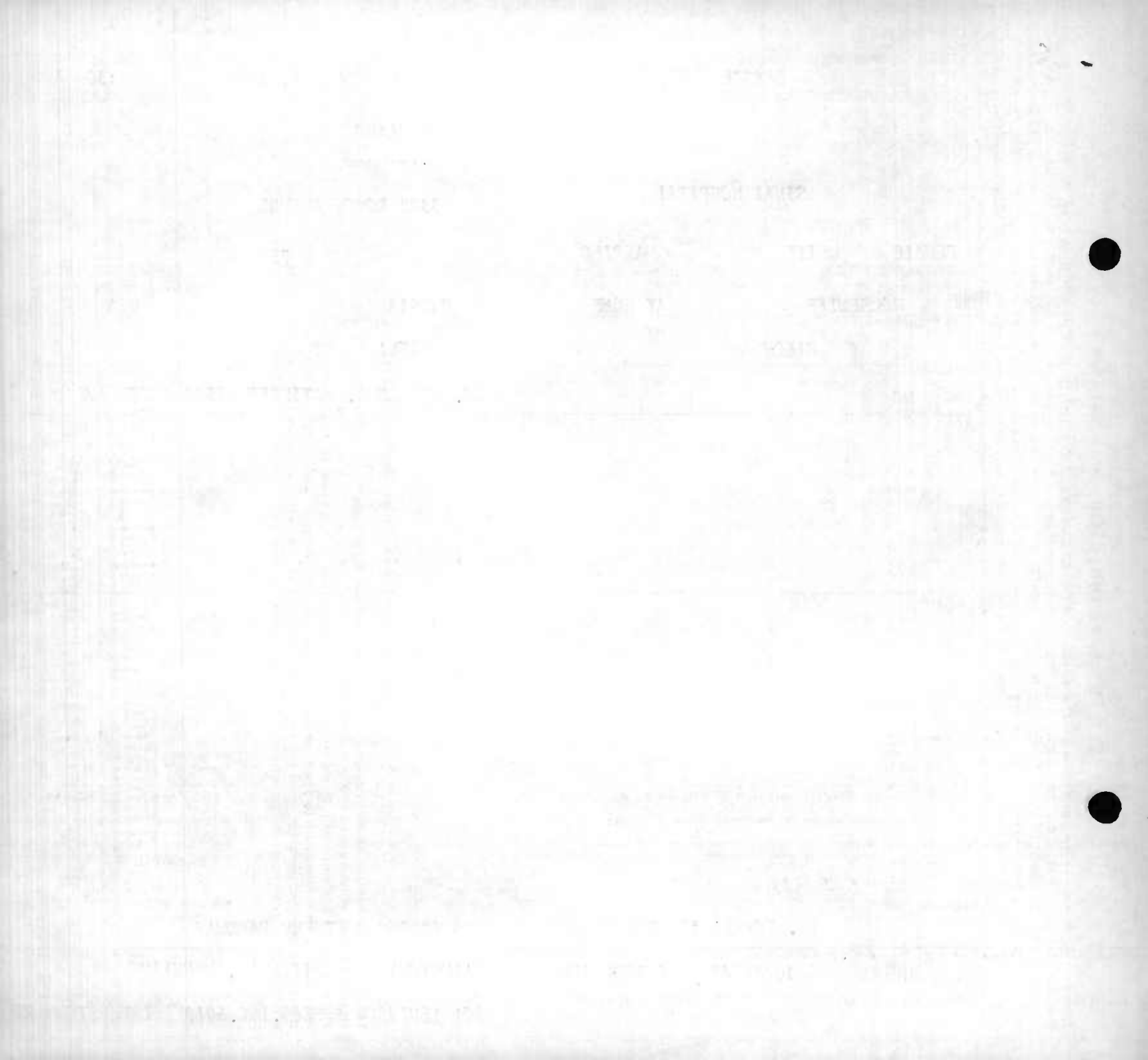




# FUNERAL DIRECTOR: IMPORTANT

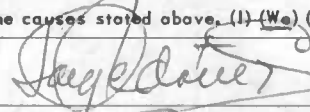
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

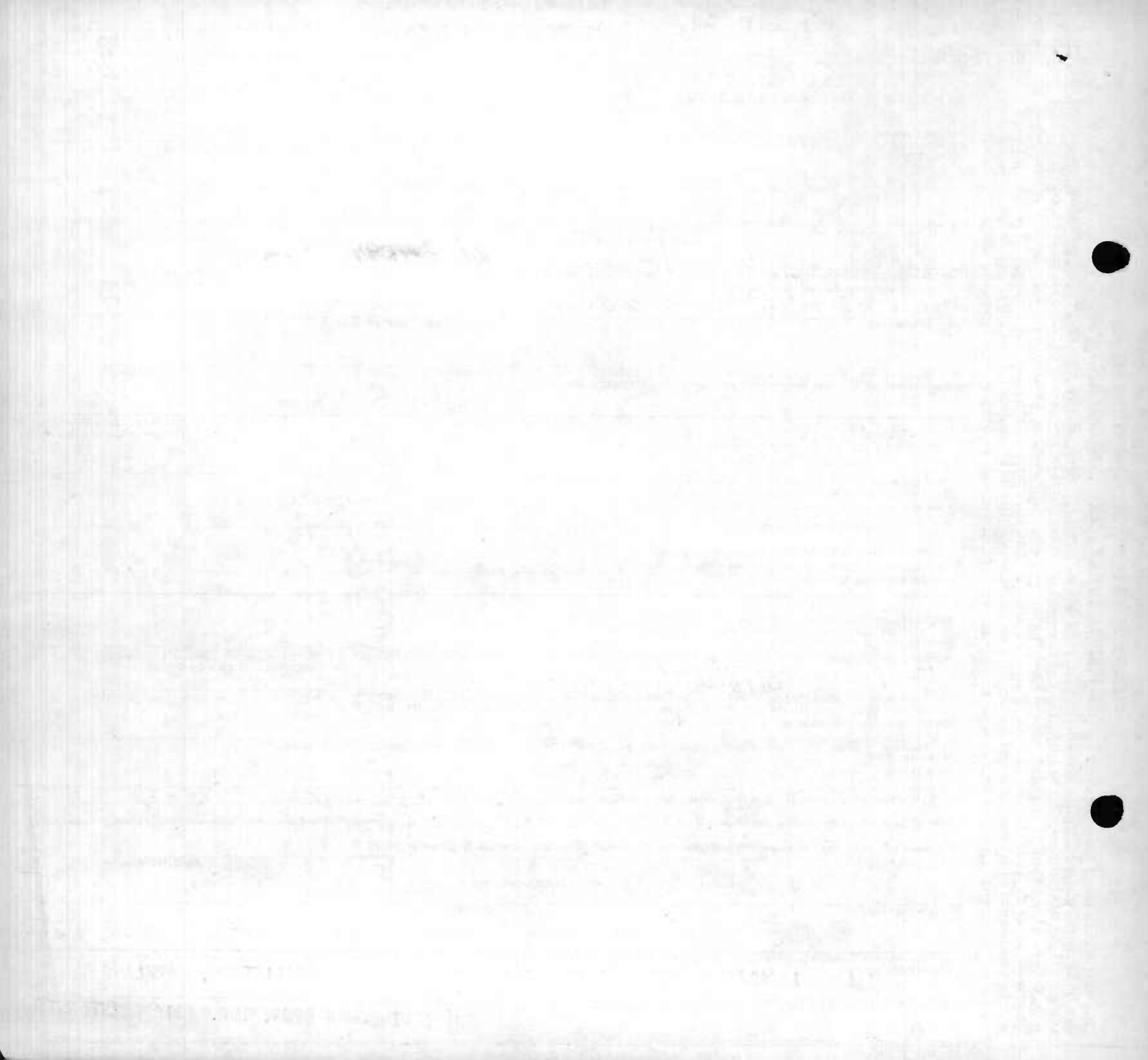
BIRTH NO. 65 11021				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11021	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BESSIE MATISOFF</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 21, 1965</b>   <b>6:30 A M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-16</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3302 ROYCE AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH		9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? BLECHMAN</b>				14. MOTHER'S MAIDEN NAME <b>GITEL ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. HERMAN S. MATISOFF</b> ADDRESS <b>3302 ROYCE AVE</b>			
18. <b>260 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Myocardial Infarction</b> DUE TO (B) <b>A S H D</b> DUE TO (C) <b>Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b> <b>15 years</b>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1937</b> to <b>10/20</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>DR. ISRAEL ZINBERG</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/21/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. ISRAEL ZINBERG</b>				23D. ADDRESS <b>4000 W NORTHERN PARKWAY</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/22/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		25B. NAME OF REGISTRAR <b>R. E. F...</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b> ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

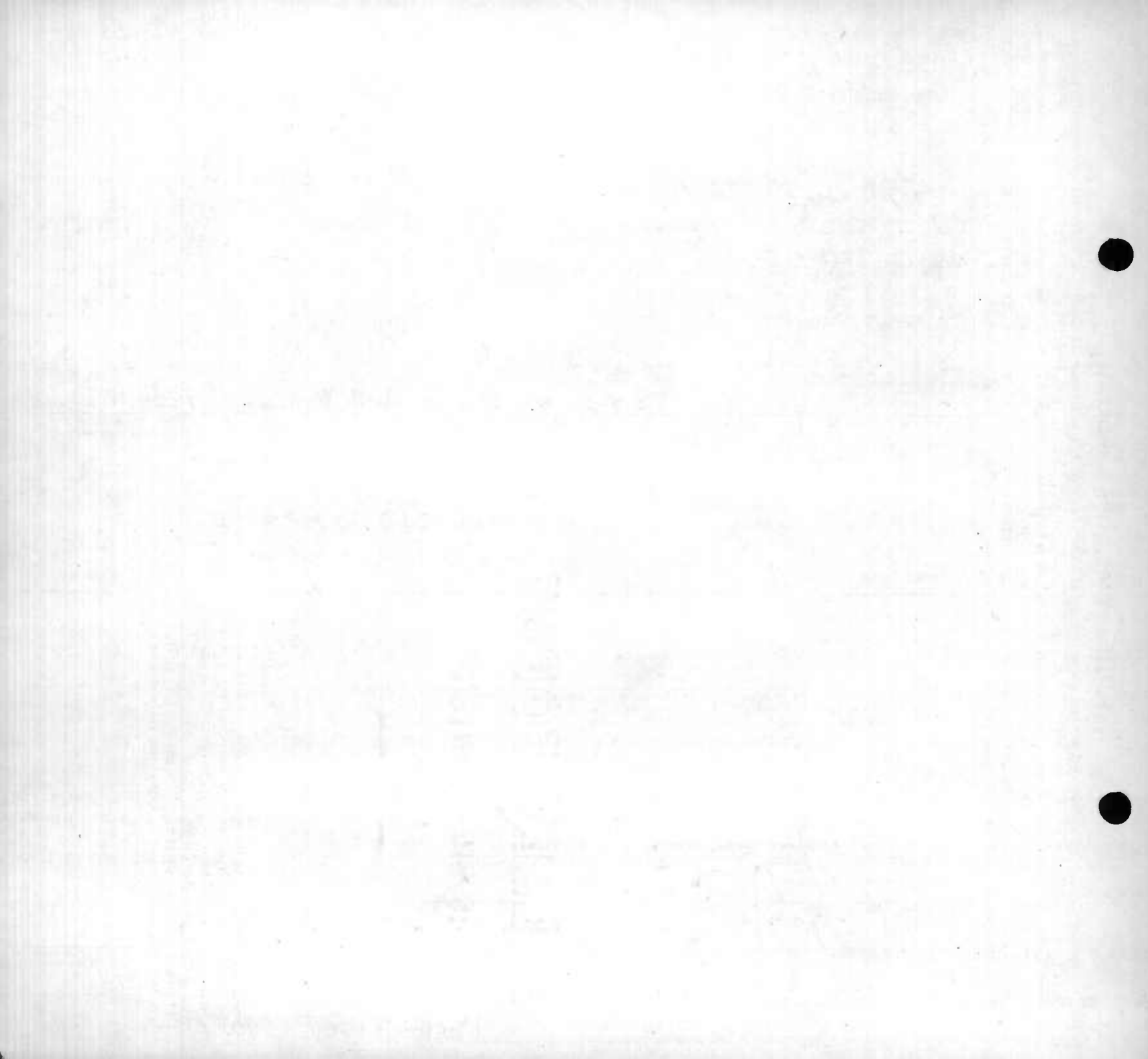
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 11022		<b>CERTIFICATE OF DEATH</b>		65 11022	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Solomon H. Goldman</b>		2. DATE AND HOUR OF DEATH <b>10-21-65 9 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital of Baltimore</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>28-02</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>4107 Kathland Ave. #7</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10/19/1897</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <b>Businessman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>S.H. Goldman &amp; Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>S</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bessie Goldman</b>	
				ADDRESS <b>4107 Kathland Ave. #7</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.1 X-260 X</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Myocardial Infarction</b>		<b>5h 11'</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Pulmonary Edema</b>			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Diabetes Mellitus</b>			
19A. DATE OF OPERATION <b>10-21-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chronic cholecystitis &amp; stones</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-18-1965</b> to <b>10-21-1965</b> , that (I) (we) last saw the deceased alive on <b>10-21-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-21-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JORGE ORDONEZ</b>		23D. ADDRESS M.D. <b>2844 OAKLEY AVE. BAL. 15.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10/22/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>BETH EL MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		25B. NAME OF REGISTRAR <b>Paul E. Ford</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 11023	
BIRTH NO. 65 11023		CERTIFICATE OF DEATH			
M.E. CASE NO. 65 11023		1. NAME OF DECEASED (Type or Print) Alexander Davis			
2. DATE AND HOUR OF DEATH 10-25-65 9:30 PM		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1619 David Hill ave 14-02		5. SEX male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			
8. DATE OF BIRTH 1-18-1913 9. AGE (In years lost birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 108. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Davis		14. MOTHER'S MAIDEN NAME Mary Alice Davis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-26-4706		17. INFORMANT Mrs. Elizabeth Watkins ADDRESS 1804 Pressman	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Carcinoma of Brain (B) DUE TO metastatic from (C) DUE TO adenocarcinoma of upper lobe of left lung			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 3 1965 to Oct 25 1965 that (I) (we) last saw the deceased alive on Oct 25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 10-26-65		23C. PHYSICIAN'S NAME (Type) [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-27-65		24C. NAME OF CEMETERY OR CREMATORY MT. Calvary	
24D. LOCATION (City, town, or County) A.A. Co.		24E. STATE (State) Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 27 1965	
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Morton + Dyett		25D. ADDRESS 1701 Laurens St.	

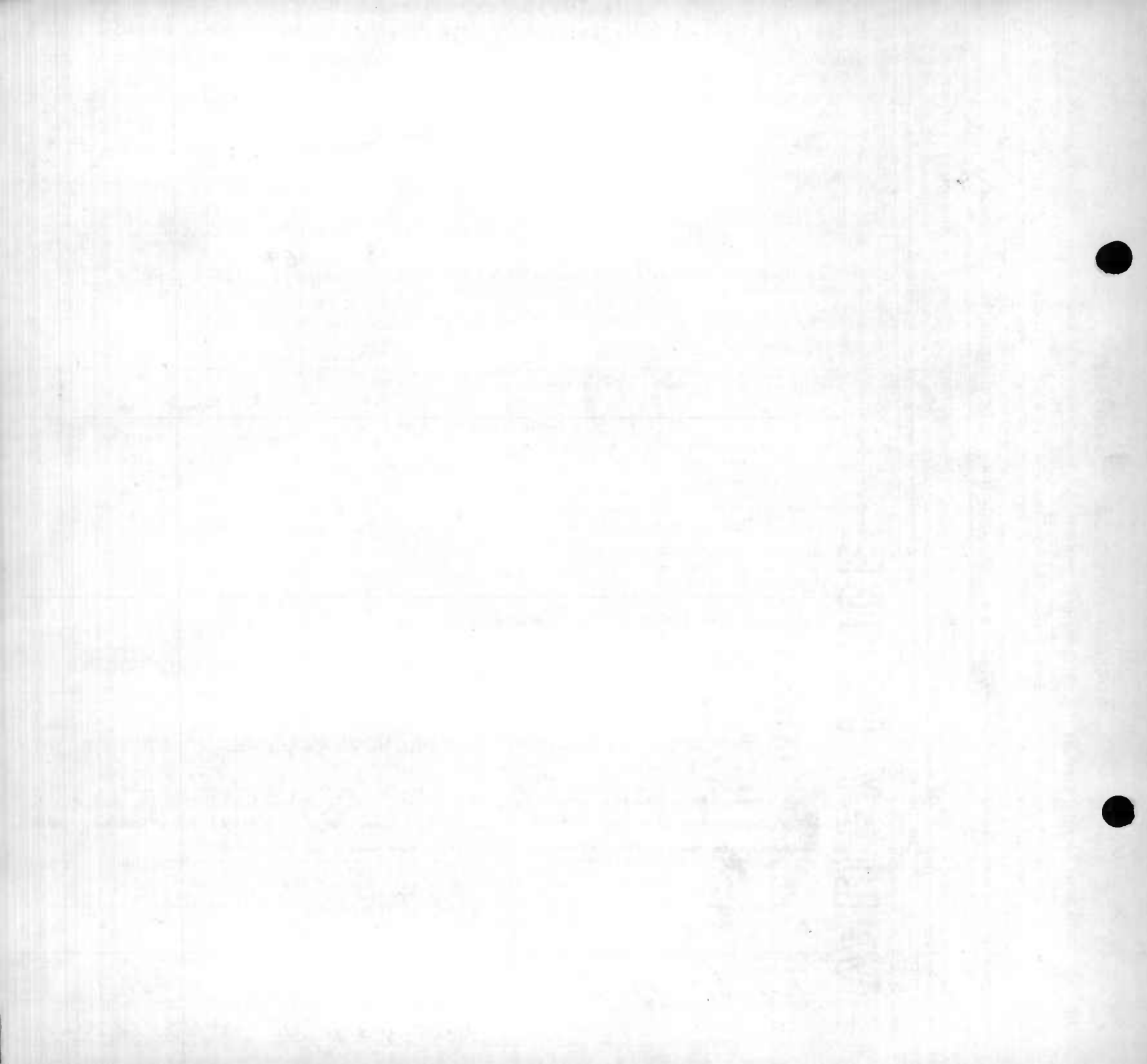


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11024				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11024	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>GEORGE WAY</b>		2. DATE AND HOUR OF DEATH <b>10-25-65</b> <b>2:05 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1802</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>36 FRANKLIN SQUARE HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 23</b>			
				D. STREET ADDRESS (If rural, give location) <b>1111 W. MULBERRY ST</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3-17-1898</b>	9. AGE (In years lost birthday) <b>67</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM WAY</b>				14. MOTHER'S MAIDEN NAME <b>NORA MILLER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEDICAL RECORD</b>		ADDRESS	
18. <b>518X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EMBOLI, bil</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>PULMONARY EMBOLI, bil</b> DUE TO (B) <b>EMPHYSEMA, LEFT</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>1-10 DAYS</b> <b>10 days</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 25 1965</b> to <b>OCTOBER 25 1965</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 25 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. V. de Boya</b>				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-25-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JACINTO V. DE BOYA</b>				23D. ADDRESS M.D. <b>FRANKLIN SQUARE HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-28-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. CARVER MEM.</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>MORTON + Pyett</b>		ADDRESS <b>1701 Laurens</b>	

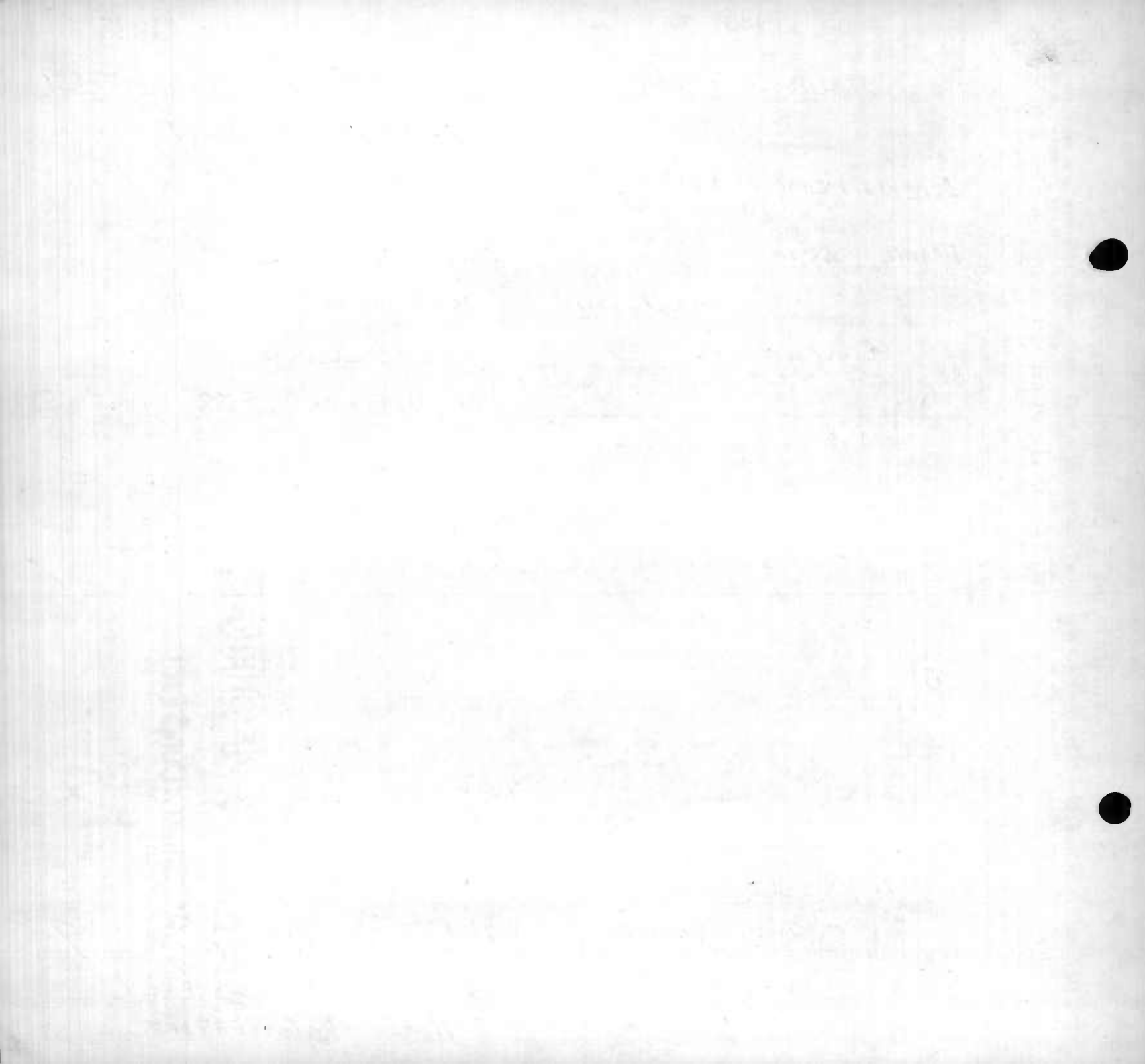




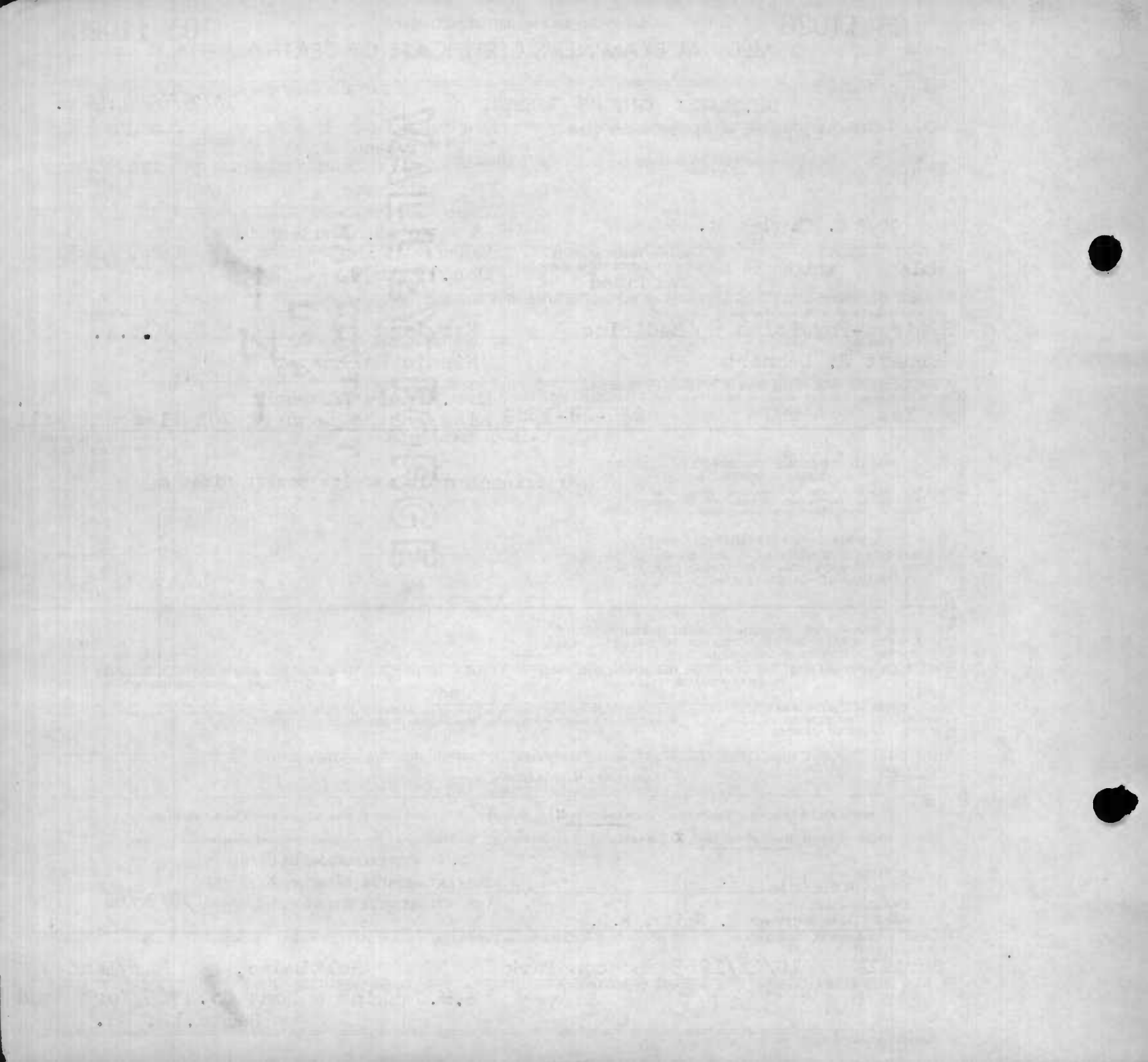
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																								
BIRTH NO. 65 11025					CERTIFICATE OF DEATH					Registered No. 65 11025														
M.E. CASE NO.										1. NAME OF DECEASED (Type or Print) <i>Mamie Porter</i>														
2. DATE AND HOUR OF DEATH <i>Oct. 23-1965-5:30 A.M.</i>																								
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>1508 Brunt Street</i> B. COUNTY <i>Baltimore Md.</i>														
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i> <i>27n. Carey St #2123</i>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>1402</i>														
D. STREET ADDRESS (If rural, give location)																								
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>May 8-1892</i>		9. AGE (In years lost birthday) <i>82</i>		10. Under 1 Yr. Months Days Hours Min.		11. Under 24 Hrs. Hours Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>					11. BIRTHPLACE (State or foreign country) <i>Unknown</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>									
13. FATHER'S NAME <i>Unknown</i>										14. MOTHER'S MAIDEN NAME <i>Unknown</i>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Mary Matthews</i>					ADDRESS <i>1508 Brunt St.</i>									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>260X I</i> <i>Cardio Vascular</i> <i>Possibly Diabetic</i> <i>Coronary</i>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO										INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																								
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>No</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <i>May 1964</i> to <i>Oct. 22 1965</i> , that (I) (we) last saw the deceased alive on <i>Oct. 22 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																								
23A. SIGNATURE <i>MR. Johnson</i>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>10-23-65</i>									
23C. PHYSICIAN'S NAME (Type)										M.D. <i>403 Med. Arts Bldg</i>					23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE <i>10-26-65</i>					24C. NAME OF CEMETERY or CREMATORY <i>MT. CALVARY</i>					24D. LOCATION (City, town, or county) (State) <i>A. A. Co Md.</i>									
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 27 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>					25C. FUNERAL DIRECTOR <i>Morton Light</i>					ADDRESS <i>1701 Levens St</i>									



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 11026	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print)		DR. ERNEST CHARLES LEHNERT		2. DATE AND HOUR PRONOUNCED DEAD 10/25/65 4:45 p.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 3003 N. Charles St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 3003 N. Charles St.	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec. 19/1879	9. AGE (In years) 85	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Physician		10B. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest J. Lehnert		14. MOTHER'S MAIDEN NAME Minnie Mullmeyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 220-44-3589		17. INFORMANT Mrs. Minnie Albrecht Miss Bertha Lehnert	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/26/65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 10/28/1965		23C. NAME OF CEMETERY or CREMATORY Loudon Park	
23D. LOCATION Baltimore, Maryland		24A. DATE REC'D BY HEALTH DEPT. OCT 27 1965		24B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		24D. ADDRESS 4905 York Road Balto. 12, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11027		BALTIC DEPARTMENT		Registered No. 65 11027	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <del>MRS</del> MARY E. HOAG		2. DATE AND HOUR OF DEATH 10/26/65 12:15 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		M. 12-06	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY	
Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 11, Md.	
		D. STREET ADDRESS (If rural, give location)		2852 WYMAN PKWY	
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6/30/87	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		OWN HOME		MATHEWS CO. VA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JAMES H. BILLUPS		MARY H. WINDER		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		213-28-1631		WILBUR W. FISH 301 NETHERINGTON DRIVE, BROOMALL, PA.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Cardio Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH (5 hrs)	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10/25/65 19 to 10/25/65 19 that (I) (we) last saw the deceased alive on 10/25/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Godfrey S. Geh</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) GODFREY S. GEH		23D. ADDRESS Union Memorial Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/29/1965		Lorraine Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 27 1965		Robert E. Taylor, M.D.		H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.	

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THOMAS B. OLCOTT

THOMAS B. OLCOTT

DR. J. J. WILSON

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11028		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11028	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Gertrude Pawlikowski</i>		2. DATE AND HOUR OF DEATH <i>Oct 27, 1965 12 45 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>New Jersey</i> B. COUNTY <i>V-27</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Linden</i>			
		D. STREET ADDRESS (If rural, give location) <i>21- W. Blanche, St</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>1-31-29</i>	9. AGE (In years lost birthday) <i>36</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>Frank Jacowski</i>			14. MOTHER'S MAIDEN NAME <i>Nicholene Pankiewicz</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>175.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>CA of Ovary - metastatic</i> DUE TO (B) <i>Hydrothorax recurrent</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>10/13/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CA Ovary</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/5</i> 19 <i>65</i> to <i>10/27</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>10/26 10 PM</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R. Wheeler</i> M.D.				23B. DATE SIGNED <i>10/27/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. C.R. WHEELER.</i>				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>Oct 27/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Mary's</i>	
24D. LOCATION <i>New Arlington N.Y.</i>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 27 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>Philip Morris Sons</i>	
				ADDRESS <i>Carlton</i>	

8502

Oct 31, 1972

PA of County Auditor  
Highest bidder

PA of County

10/15/72

10/30/72

10/30/72

10/30/72

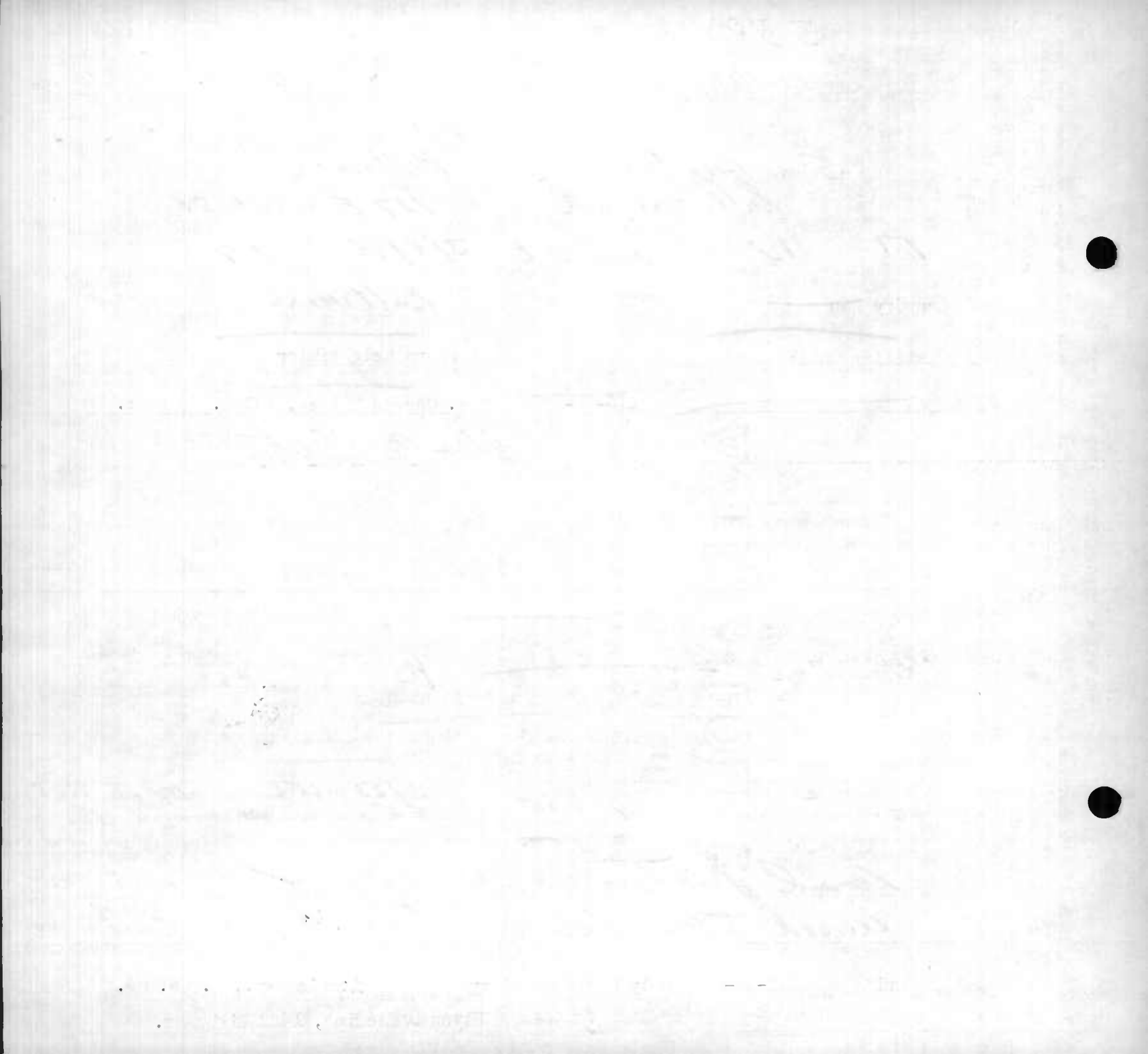
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*[Signature]*

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11029	
BIRTH NO. 65 11029		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mullen, John J.</i>		2. DATE AND HOUR OF DEATH <i>10-26-65 12:50 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>24-03</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital Baltimore, Md.</i>		D. STREET ADDRESS (If rural, give location) <i>127 E. West St.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>3/8/98</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundry Man</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Mullen</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Reicheimier</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-8795</i>		17. INFORMANT ADDRESS <i>Mrs. Carrie Mullen, 127 E. West St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>154 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</i>		CAUSE OF DEATH (A) DUE TO <i>Polio-Ca of Rectum</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Rectum in 1962</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <i>9/23 1965</i> to <i>10/26 1965</i> , that (X) (we) lost saw the deceased alive on <i>10-25 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Leonard J. Heitzberg</i>		23B. DATE SIGNED <i>10-26-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Leonard J. Heitzberg</i>		23D. ADDRESS <i>Sinai Hospital Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-29-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Ritchie Hwy., A. Co. Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>OCT 27 1965</i>		24F. NAME OF REGISTRAR <i>Robert E. Farber, MD</i>	
24G. FUNERAL DIRECTOR <i>Flynn &amp; Fleming, 1422 Light St.</i>		24H. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 11030</u>	
BIRTH NO. <u>0413 65 11030</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Marie L. Oliphant</u>		2. DATE AND HOUR OF DEATH <u>10/26/65</u> <u>4:50</u> <u>AM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>7 Mercy Hosp. Baltimore Md</u>		A. STATE <u>Md</u> B. COUNTY <u>26-08</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>3734 Mt Pleasant Ave Balto 24</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/16/86</u>	9. AGE (In years lost birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown Frederick P. Skuhr</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown Annie Meier</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT ADDRESS <u>Hosp Chart</u>			
18. <u>422.11</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Congestive Heart Failure</u> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Calcific Aortic Stenosis</u> DUE TO			
		(C) <u>ASCVD</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>10/8</u> <u>1965</u> to <u>10/26</u> <u>1965</u> , that (we) last saw the deceased alive on <u>10/26</u> <u>1965</u> and that in (my) <del>the</del> opinion death occurred on the date and hour and from the causes stated above. (We) (did) <del>the</del> view the body after death.					
23A. SIGNATURE <u>Chester C. Collins Jr</u>				23B. DATE SIGNED <u>10/26/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Chester C. Collins Jr</u>				23D. ADDRESS <u>M.D. Mercy Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/29/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto Nat'l Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 27 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph H. Ziemisch</u>		25D. ADDRESS <u>263 S. Norbling St</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 11031</u>	
BIRTH NO. <u>65 11031</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Louis Avig</u>		2. DATE AND HOUR OF DEATH <u>October 26, 1965</u> <u>9:15 PM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph's Hospital</u> <u>1400 N. Caroline St. #13</u>		A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, Maryland 21213</u> D. STREET ADDRESS (If rural, give location) <u>4016 Raymond Ave. 03-00</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>7/5/1906</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: <u>3</u> Days: <u>20</u> If Under 24 Hrs. Hours: <u>2</u> Min. <u>45</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Crown Bolt &amp; Seal</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Avig</u>		14. MOTHER'S MAIDEN NAME <u>Fredericka</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-8548</u>		17. INFORMANT <u>Mrs. Juanita Bane- 4014 Balfern Ave. #13</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion, Acute</u>		19. CAUSE OF DEATH <u>Coronary Occlusion, Acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8:05-9:15 PM</u> <u>released on approval</u>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 26, 1965</u> to <u>Oct. 26, 1965</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Oct. 26, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. <u>Staff Physician</u>		23. SIGNATURE <u>Fausto Q. Aquino, Jr. M.D.</u> 23C. PHYSICIAN'S NAME (Type) <u>Fausto Q. Aquino, Jr. M.D.</u> 23D. ADDRESS <u>St. Joseph's Hospital</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/30/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u>	
24D. LOCATION <u>BALTO. MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 27 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkus, MA</u>	
25C. FUNERAL DIRECTOR <u>Joseph P. Zannino</u>		25D. ADDRESS <u>263 S. Conkley St.</u>			



RECEIVED THE SECRETARY OF THE

FUNERAL DIRECTOR: IMPORTANT

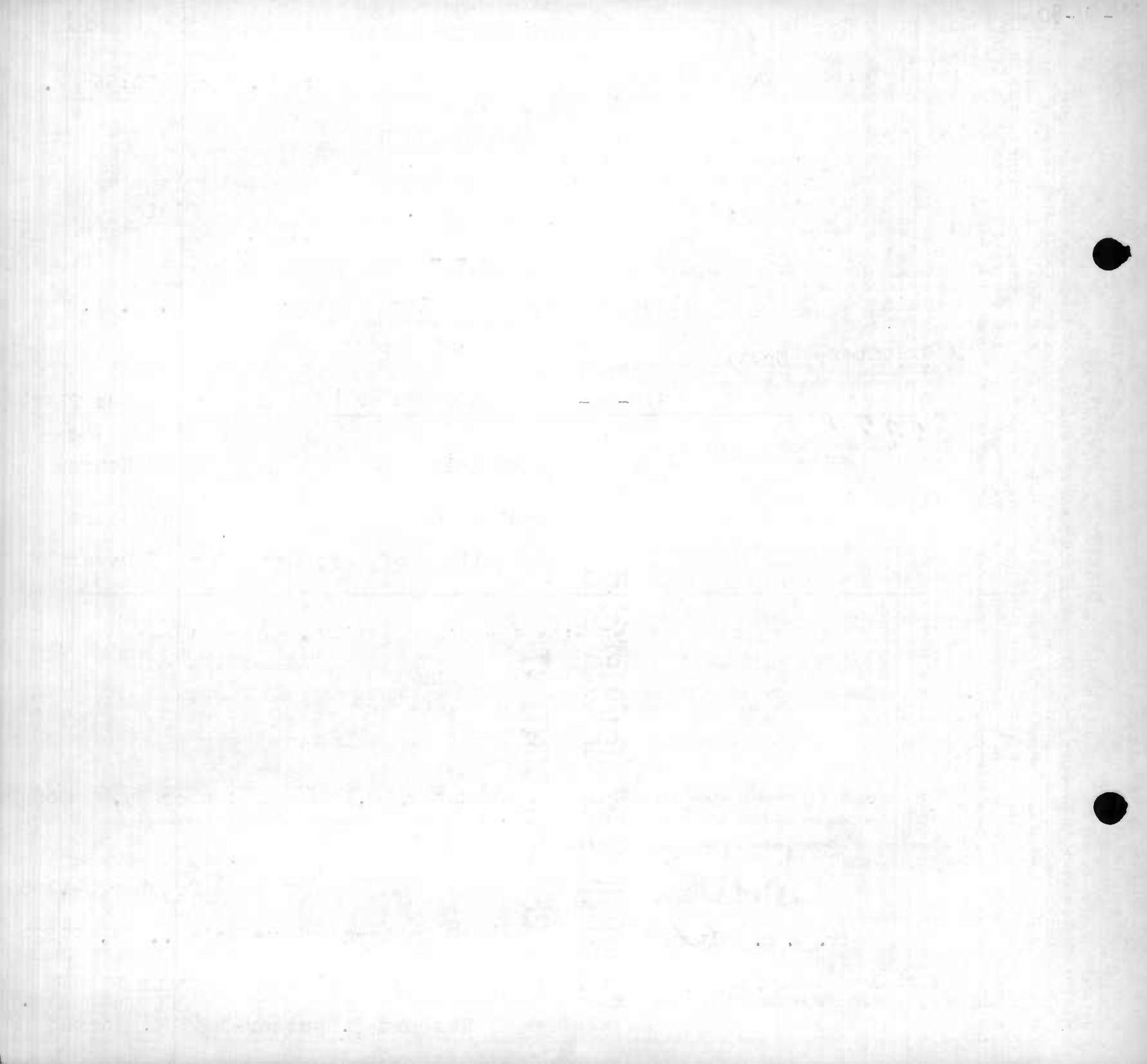
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 11032</u>	
BIRTH NO. <u>65 11032</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Charlotte Williams</u>		2. DATE AND HOUR OF DEATH <u>21 Oct 1965</u> <u>2:40 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>13-04</u>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2908 Parkwood Ave #17</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>2/26/24</u>	9. AGE (In years last birthday) <u>41</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>College Library</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John P. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Grace Ann Williams</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-20-2657</u>		17. INFORMANT ADDRESS <u>Mrs. Grace A. Williams - 2908 Parkwood Ave</u>	
18. <u>092X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Subacute Yellow Atrophy of the Liver</u> DUE TO <u>Hepatitis, infectious vs. serum</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Inferior vena caval ligation for Rx of pulmonary embolism &amp; ? Blood transfusion.</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>41</u> (this hospital) attended the deceased from <u>30 Sep 1965</u> to <u>21 Oct 1965</u> , that (I) <u>lost</u> saw the deceased alive on <u>21 Oct 1965</u> and that in (my) <u>lost</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> (did) view the body after death.					
23A. SIGNATURE <u>Solomon Robbins</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>21 Oct 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Solomon Robbins</u>		23D. ADDRESS <u>Sinai Hospital, Baltimore Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/25/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>ARBUTUS MEMORIAL PARK</u>	
24D. LOCATION (City, town, or county) (State) <u>ARbutus BALto Co, MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 27 1965</u>		25B. NAME OF REGISTRAR <u>Robt E. Talbott</u>	
25C. FUNERAL DIRECTOR <u>HERBERT E. NOTTER</u>		ADDRESS <u>3035 W. NORTH AVE</u>			

10/28/65 - Infectious Hepatitis - Serum Hepatitis  
ruled out. Information received from  
Dr. S. Robbins, Sinai Hospital via phone  
gc.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11033	
BIRTH NO. 65 11033				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Mabel Scott				October 24, 1965 10:55 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY Baltimore	
5. SEX Female				6. RACE Negro	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced				8. DATE OF BIRTH 2-8-1898	
9. AGE (In years last birthday) 67				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Greenberry Scott				14. MOTHER'S MAIDEN NAME Annie Dades	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 219-30-8708				16. SOCIAL SECURITY NO. RECORDS: BCH 4940 Eastern Avenue 21224	
17. INFORMANT ADDRESS				18. CAUSE OF DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 24 Hours	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Septicemia				48 Hours	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardio-Vascular Disease				25 Days	
22. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 30, 1965 to October 24, 1965, that (I) (we) last saw the deceased alive on October 24, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Dr. D. M. Baltzan M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED October 24, 1965 23C. PHYSICIAN'S NAME (Type) Dr. D. M. Baltzan M.D. 23D. ADDRESS 4940 Eastern Avenue Balto., Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 10/28/65	
24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 27 1965				25B. NAME OF REGISTRAR Herbert E. Nutter	
25C. FUNERAL DIRECTOR ADDRESS Ave. 3035 W. North					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11034		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11034	
M.E. CASE NO.		CERTIFICATE OF DEATH		2	
1. NAME OF DECEASED (Type or Print) MEISZ, HENRY MICHAEL JR		2. DATE AND HOUR OF DEATH OCTOBER 25, 1965 11:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)		B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE OVERLEA			
		D. STREET ADDRESS (If rural, give location) 7110 BELAIR RD.			
5. SEX M	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH DEC. 9, 1905	9. AGE (In years lost birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY PRODUCE HOS.	11. BIRTHPLACE (State or foreign country) BALTIMORE, M.D.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HENRY MEISZ		14. MOTHER'S MAIDEN NAME FRANCES SMITH		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO	
16. SOCIAL SECURITY NO. HA 216-10-8338		17. INFORMANT CHARTY/DORIS T. MEISZ		ADDRESS 7110 BELAIR ROAD	
18. 422.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE		21 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT. 10 19 65 to OCT 25 19 65, that (I) (we) last saw the deceased alive on OCT 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles E. Boring Jr.				23B. DATE SIGNED 10/25/65	
23C. PHYSICIAN'S NAME (Type) DR. CHARLES E. BORING, JR				23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE OCT 28-65		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY	
24D. LOCATION (City, town, or county) (State) TAYLOR AVENUE MARYLAND		24E. DATE REC'D BY HEALTH DEPT. OCT 27 1965		24F. NAME OF REGISTRAR Robert E. Farley M.D.	
24G. FUNERAL DIRECTOR Doppel Brothers		24H. ADDRESS 7110 BELAIR ROAD		24I. 21206	

RECEIVED - 11 OCTOBER 1962

WYLAND  
BALTIMORE  
210 DEAR RD.

UNION MEMORIAL HOSPITAL

DEC 9, 1962

M. GARCIA

BALTIMORE, MD. U.S.A.

RETIRED

FRANCES SMITH

HENRY WEISS

HA CHART

RETIRED

ARTIFICIAL CEMENTATION  
DENTURE

NO

OCT 10 1962

Charles E. Boring

X





VALLEY FORT

REPORT

1  
623

65 11036

BALTIMORE CITY HEALTH DEPARTMENT

65 11036

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN PROCTOR

2. DATE AND HOUR PRONOUNCED DEAD

10/26/65 1:50 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2525 BELVEDERE AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2528 W. Cold Spring Lane

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

Sept. 30, 1890

9. AGE (In years last birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

UNKNOWN

10B. KIND OF BUSINESS OR INDUSTRY

----

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

MINNIE TATEM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

UNKNOWN

17. INFORMANT

M.

ADDRESS

MADGE M. PROCTOR 204 FAIRFIELD AVE. N.J.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/26/65

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

10/29/65

23C. NAME of CEMETERY or CREMATORY

Lake Nelson Memorial Park Piscataway, New Jersey

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 27 1965

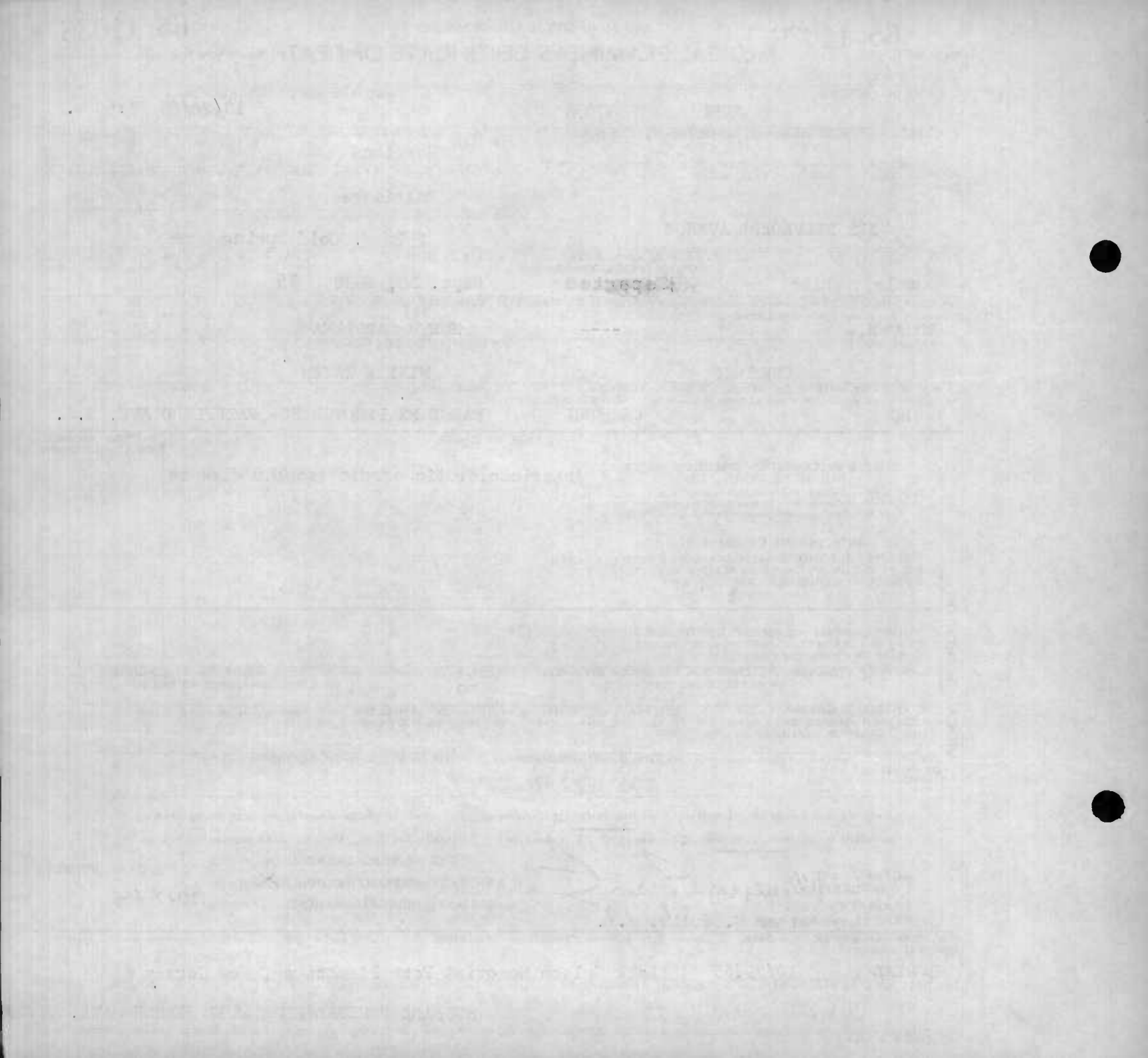
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11037		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11037	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Robert Gerald Norton		2. DATE AND HOUR OF DEATH 10-24-65 750 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-01			
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	
8. DATE OF BIRTH 4-14-64		9. AGE (In years last birthday) 18 mos		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Randall Jones	
14. MOTHER'S MAIDEN NAME Dorothy Norton		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother Dorothy Norton		ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 2nd & 3rd Degree Burns, 70-80% body surface		INTERVAL BETWEEN ONSET AND DEATH 16 hrs prior to death			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 845 W. Lexington St. 18-01	
21D. TIME OF INJURY (APPROX.) October 23, 1965 3:00 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Flame burns	
22. I certify that (this hospital) attended the deceased from 3:10 P.M. 10-23-1965 to 7:50 A.M. 10-24-1965, that (I) (the) last saw the deceased alive on 10-24-1965 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did) (did not) view the body after death.					
23A. SIGNATURE Francis A. Clark Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-24-65	
23C. PHYSICIAN'S NAME (Type) FRANCIS A. CLARK, JR.		M.D. 23D. ADDRESS 90 University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 23 1965		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 27 1965		25B. NAME OF REGISTRAR R. E. Farber	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schenck St.			

RECEIVED

RECEIVED

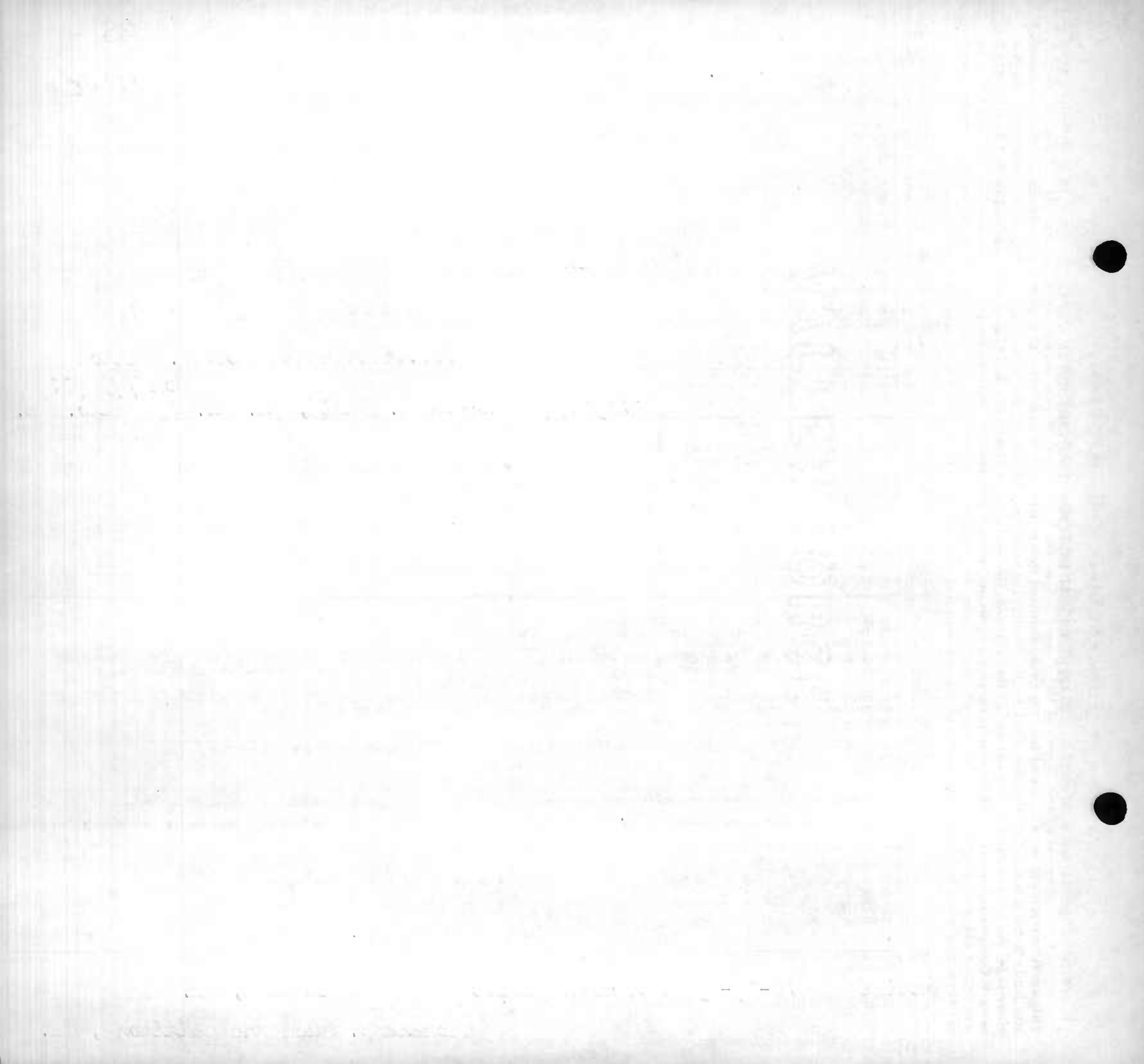


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 11038		CERTIFICATE OF DEATH		65 11038	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		BASIL M. FLORENCE		10-26-65 11:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Church Home + Hospital		Maryland 2706			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		6113 FAIR OAKS AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	B. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	Widowed	11-9-89	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Maryland		USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Dukas		Mary M. Benton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		
		212526740	Howard N. Basil, Jr. Rt. 13 Balto. Md.		
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osphenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		Co (2) lung with			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		pleural effusion and			
		(B) DUE TO			
		Generalized metastasis			
		(C) _____			
II		INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		mos.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10-16 19 65 to 10-26 19 65, that (I) (we) last saw the deceased alive on 10-26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Jose P. Mainsag				10-26-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Jose S. Mainsag		M.D. Church Home + Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
burial		10-29-65		Parkwood Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 27 1965		Robert E. Taylor		Leonard J. Ruck Inc Baltimore, Md.	
25D. ADDRESS					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11039		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11039	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM ROBERT BIRCKHEAD</b>		2. DATE AND HOUR OF DEATH <b>OCT 25, 1965. 5:20 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <b>MARYLAND</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>FRANKLIN SQUARE HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE #14</b>		D. STREET ADDRESS (If rural, give location) <b>3206 TYNDAL AVE</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12/10/01</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Koppers Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILLIAM BIRCKHEAD</b>		14. MOTHER'S MAIDEN NAME <b>WHEATLEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO. <b>217-14-1158</b>		17. INFORMANT <b>Mrs. Ethel Birckhead</b> ADDRESS <b>(Same)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <b>septicemia</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>lobar pneumonia</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 25 1965</b> to <b>OCT 25 1965</b> , that (I) (we) last saw the deceased alive on <b>OCT 25 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>JANE V. DEL PILAR</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>JANE V. DEL PILAR</b>		23D. ADDRESS <b>FRANKLIN SQUARE HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/28/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>	

WILLIAM ROBERT BIRCHHEAD

Oct 22 1954

FRANKLIN SENIOR HOSPITAL BALTIMORE  
3506 LINDSEY  
12/10/01 63  
MARRIED

WILLIAM BIRCHHEAD  
NICK MARRIED  
MARYLAND

NSA

paper business  
experience

Oct 22

Oct 22 1954

JOHN A. DEW TILK  
JAMES A. DEW

FRANKLIN SENIOR HOSPITAL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11040</b>	
BIRTH NO. <b>65 11040</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Reginald Griffiths (Ezekiah)</b>		2. DATE AND HOUR OF DEATH <b>October 25, 1965 8:25 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division Street Baltimore, Maryland</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1629 Bakebury Court</b>			
5. SEX <b>87 M</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12-25-1878</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W. Indies</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Remoo Griffiths</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW1</b>		16. SOCIAL SECURITY NO. <b>213-05-1850</b>		17. INFORMANT <b>Ayrie Warters 1612 Westwood Ave.</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CUA</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 25, 1965</b> to <b>October 25, 1965</b> , that (I) (we) last saw the deceased alive on <b>October 25, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. Moonday, M.D.</b>				23B. DATE SIGNED <b>October 26, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>G. Moonday</b>				23D. ADDRESS <b>1514 Division Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-28-65</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Peter's Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Libertytown, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>OCT 27 1965</b>		24F. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
24G. FUNERAL DIRECTOR <b>George A. Kilar</b>		24H. ADDRESS <b>1348 N. Calhoun St</b>			

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 11041	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print)		VIRGINIA TAYLOR		2. DATE AND HOUR PRONOUNCED DEAD 10/26/65 12:26 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		A. STATE Maryland B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2301			
		D. STREET ADDRESS (If rural, give location) 927 Bevan St.			
5. SEX female	6. RACE colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 8/4/23	9. AGE (In years lost birthday) 42	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mathews Taylor			14. MOTHER'S MAIDEN NAME Gladys Taylor		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Gladys Dorsey 2214 W. North Ave.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Fatty liver DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
				DATE SIGNED 10/26/65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		10/30/65		Mt. Auburn	
				23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
OCT 27 1965		Robert E. Taylor, M.D.		Charles A. Rice 661 W. Barre St.	

WALLLEY

FOUR



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11042		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11042	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Frank Ingrassia			2. DATE AND HOUR OF DEATH 10/24/65 how Un known M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2004		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Death at Home. Transferred 4 South Willard Street			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4 WILLARD STREET		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 2-13-42	9. AGE (In years last birthday) 23	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME THOMAS INGRASSI		
14. MOTHER'S MAIDEN NAME IRMA PARSON			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT ADDRESS 4 S. Willard St. Baltimore, Md.		
18. CAUSE OF DEATH					
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO Tetralogy of Fallot		INTERVAL BETWEEN ONSET AND DEATH Birth	
(B) DUE TO		(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/11 19 65 to 10/19 19 65, that (I) (we) last saw the deceased alive on 10/19 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Virgil Brown				23B. DATE SIGNED 10/24/65	
23C. PHYSICIAN'S NAME (Type) VIRGIL BROWN				23D. ADDRESS Johns Hopkins Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-27-65		24C. NAME of CEMETERY or CREMATORY Mt. Nebo	
24D. LOCATION Delta, York Co., Penna		25A. DATE REC'D BY HEALTH DEPT. OCT 28 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR John H. Harkins		25D. ADDRESS Delta, Penna.	

Put Home, T. J. J.

Technology of Fallot

Uphill

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11043				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11043	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>MILDRED PAULINE WIDERMANN</b>		2. DATE AND HOUR OF DEATH <b>October 25, 1965 5:45 AM.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore County</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Long Beach 53700</b>			
				D. STREET ADDRESS (If rural, give location) <b>Box 263 Rt. 15</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) <b>Married</b>	8. DATE OF BIRTH <b>10/27/18</b>	9. AGE (In years lost birthday) <b>47</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Oscar Leroy Houser</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Reichel</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Medical Records</b>		ADDRESS	
18. <b>202.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <b>Septicemia, suspected</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(B) <b>Symptoms, unspecified</b> DUE TO		<b>5 mos</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>10/28/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 7</b> 1965 to <b>Oct. 25</b> 1965, that (I) (we) last saw the deceased alive on <b>Oct. 24</b> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Barry N. Rosenbaum</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/25/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>BARRY N. ROSENBAUM</b> M.D.				23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/28/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Old Court Road</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	



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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11044		CERTIFICATE OF DEATH		Registered No. 65 11044	
1. NAME OF DECEASED (Type or Print) <b>FRANK T. STACHS</b>				2. DATE AND HOUR OF DEATH <b>10/25/65 9:07 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>231 S. WOLFE ST.</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>9-18-99</b>	9. AGE (In years lost birthday) <b>66</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Atlantic Refining Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>MICHAEL STACHS</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE OLES</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>215-01-9419</b>		17. INFORMANT ADDRESS <b>845 Lake Drive - Zone 17</b> <b>L. Richard Stachs, son,</b>			
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>INTRACEREBRAL HEMORRHAGE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) <b>INTRACEREBRAL HEMORRHAGE</b> DUE TO (B) <b>HYPERTENSION</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>? 20 years</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10/24</b> 19 <b>65</b> to <b>10/25</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10/25</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Jan Shank</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/25/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>IAN SHENK</b>				23D. ADDRESS <b>550 N. BROADWAY BALTO., MD.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/29/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>					

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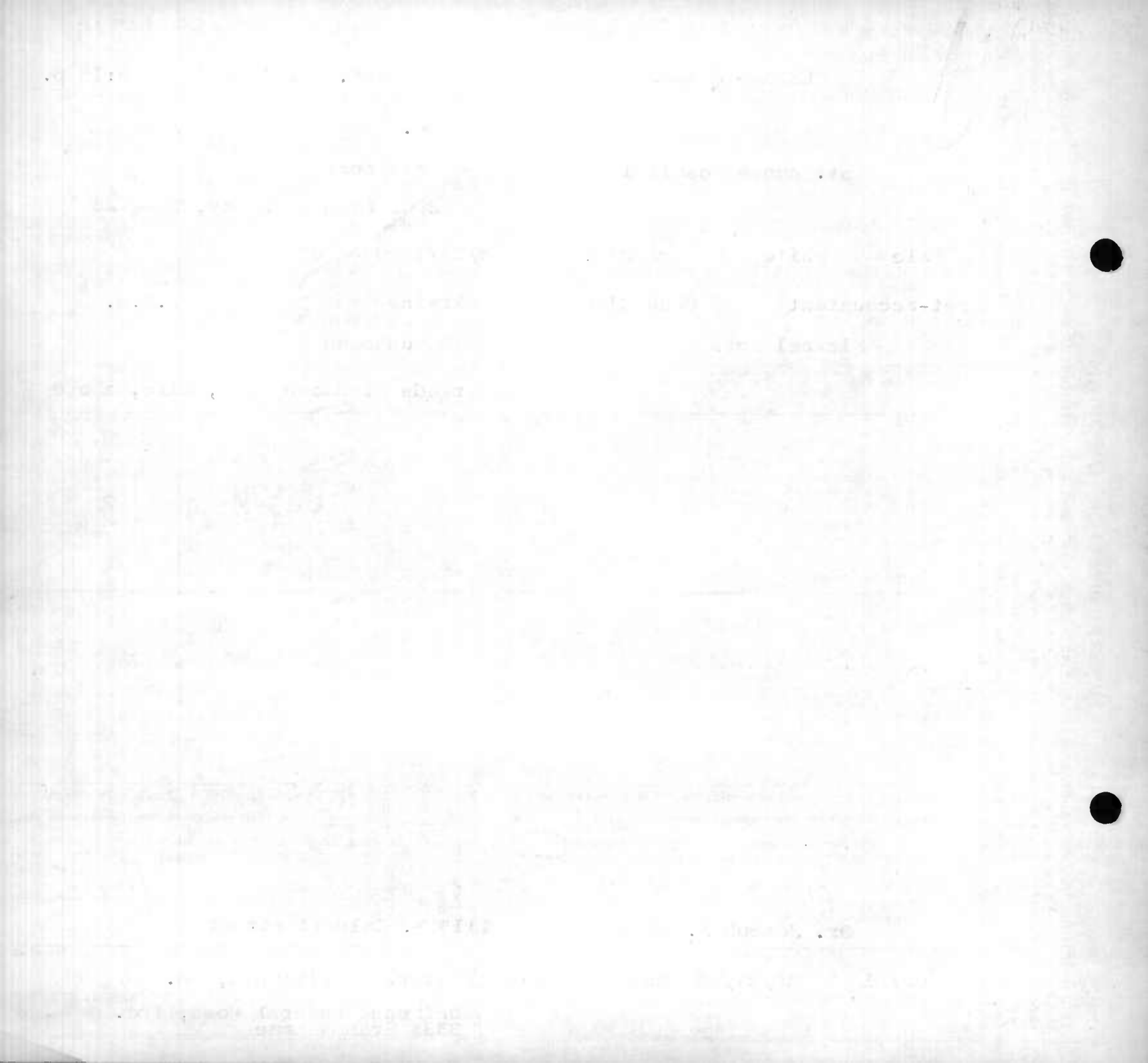
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BIRTH NO. <span style="font-size: 2em;">65 11045</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 2em;">65 11045</span>	
1. NAME OF DECEASED (Type or Print) <b>ALEXANDER KOSS</b>			2. DATE AND HOUR OF DEATH <b>Oct. 24, 1965</b> <span style="float: right;"><b>3:15 p.</b> M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Agnes Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2003 Fern Glen Way, Zone 28</b>		
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>3/25/1900</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret-accountant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Copa Club</b>	11. BIRTHPLACE (State or foreign country) <b>Ukraine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Michael Koss</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Elfriede Biedmann Koss, wife, above</b>		
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/29</b> 19 <b>55</b> to <b>8/27</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>8/27</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph S. Blum</b>				23B. DATE SIGNED <b>10/26/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Joseph S. Blum</b>		23D. ADDRESS M.D. <b>1115 N. Calvert Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/27/65</b>	24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1965</b>		25B. NAME OF REGISTRAR <b>P. A. E. Falkner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11046	
BIRTH NO. 65 11046		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HERMINA ZADERA		2. DATE AND HOUR OF DEATH Oct. 26, 1965 11:30 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 816 N. Port Street Baltimore, Md., 21205		A. STATE Md. B. COUNTY 7-02			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 816 N. Port Street			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5/20/1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Linka			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS August Zadera, Sr., husband, above		
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Diabetes mellitus DUE TO (B) Gangrene - rt leg DUE TO (C) Valvular Heart disease		INTERVAL BETWEEN ONSET AND DEATH 11 yrs. 1 week 2.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 19 54 to Oct 26 19 65, that (I) (we) last saw the deceased alive on Oct 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis Klimes		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/27/65	
23C. PHYSICIAN'S NAME (Type) Dr. Louis Klimes		23D. ADDRESS M.D. 2623 E. Monument Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/30/65	24C. NAME of CEMETERY or CREMATORY Bohemian National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 28 1965		25B. NAME OF REGISTRAR R. E. Farber		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.	

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11047</b>	
BIRTH NO. <b>65 11047</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ANNA B. LEISTER</b>		<b>Oct. 24, 1965</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1737 E. 35th St.</b>		A. STATE <b>Maryland</b> B. COUNTY <b>902</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1737 E 35th St.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 16, 1866</b>
9. AGE (In years lost birthday) <b>99</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Sprinkle</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Derr</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Eva Mulcahy</b>		ADDRESS <b>1737 E. 35th St. Baltimore, Md.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion, Coronary Sclerosis, Hypotension</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>arterio sclerosis / Gen'l</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Seriously - Malnutrition - multiple Sclerotic plaques</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Oct. 4 1965</b> to <b>Oct. 24 1965</b> , that (1) (we) lost saw the deceased alive on <b>Oct. 24 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Walter A. Anderson</b>		23B. DATE SIGNED <b>Oct. 26-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>M.D.</b>		23D. ADDRESS <b>M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-27-65</b>	24C. NAME of CEMETERY or CREMATORY <b>Leister's Lutheran</b>	24D. LOCATION (City, town, or county) (State) <b>Carroll Co. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1965</b>	25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	25C. FUNERAL DIRECTOR <b>Tipton-Eline</b>	ADDRESS <b>Hampstead, Md.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65-2445</u>		65 11048		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 11048</u>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>BABY BOY DERBY</u>				2. DATE AND HOUR OF DEATH <u>Oct 27, 1965</u> <u>1:25</u> <u>A</u> M.			
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>				A. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>27-38</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>md. GEN. Hosp.</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>12</u>			
				D. STREET ADDRESS (If rural, give location) <u>1652 WAVERLY WAY</u>			
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>N.B.</u>	8. DATE OF BIRTH <u>Oct 26, 1965</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Austin DERBY</u>				14. MOTHER'S MAIDEN NAME <u>Frances Theresa WAGNER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>762.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>atalectasis - complete</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prematurity (32 weeks)</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 26</u> 19 <u>65</u> to <u>Oct 27</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Oct 27</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. Maldonado</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10-27-65</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/28/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 28 1965</u>		25B. NAME OF REGISTRAR <u>R. E. Talley</u>		25C. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>		ADDRESS	





D-143

65 11049

BALTIMORE CITY HEALTH DEPARTMENT

65 11049

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN V.O. DUFFIELD, SR.

2. DATE AND HOUR PRONOUNCED DEAD

10/25/65 4:30 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

DUNDALK

21222

D. STREET ADDRESS (If rural, give location)

6910 Ridgeway Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

SEPT. 7, 1899

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY

AUTOMOBILE

11. BIRTHPLACE (State or foreign country)

NEW JERSEY

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

NATHANIEL DUFFIELD

14. MOTHER'S MAIDEN NAME

CATHERINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

5/14/1955

5/13/22

216/09/8286

16. SOCIAL  
SECURITY NO.

17. INFORMANT

AS IN ADDRESS

ANNA W. DUFFIELD--NO. 4 ABOVE

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

10/26/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

OCT. 29, 1965

23C. NAME of CEMETERY or CREMATORY

MEADOWBRIDGE

23D. LOCATION

(City, town, or county)

(State)

DORSEY

BALTIMORE CO., MD.

24A. DATE REC'D BY HEALTH DEPT.

OCT 28 1965

24B. NAME OF REGISTRAR

P. L. E. F. J. J. J.

24C. FUNERAL DIRECTOR

W. BROOKS BRADLEY, DUNDALK, MD.

VALLEY FORGE

1  
M-460

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **65 11050** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 11050**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **Baby BRYAN MILLER** 2. DATE AND HOUR PRONOUNCED DEAD **10/25/65 2:15 p. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY **B. COUNTY**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **1701 Pumphrey Ave.**

5. SEX **male** 6. RACE **white** 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH **July 4, 1965** 9. AGE (In years last birthday) **4** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **BALTO. Md.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Edward J. Miller** 14. MOTHER'S MAIDEN NAME **Joyce Widdis**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS **MR. Edward J. Miller**

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH **Interstitial pneumonitis** (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **10/26/65** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **OCT 28, 1965** 23C. NAME OF CEMETERY or CREMATORY **BALTO. NAT. CEM.** 23D. LOCATION (City, town, or county) (State) **BALTO. Md.**

24A. DATE REC'D BY HEALTH DEPT. **OCT 28 1965** 24B. NAME OF REGISTRAR **Robert E. Farley** 24C. FUNERAL DIRECTOR ADDRESS **G. Truman Schwab**

VS 151-REV. 7/1/65 3512 Frederick Ave. (29)

VALLEY FORTRESS

THE CONTINENTAL

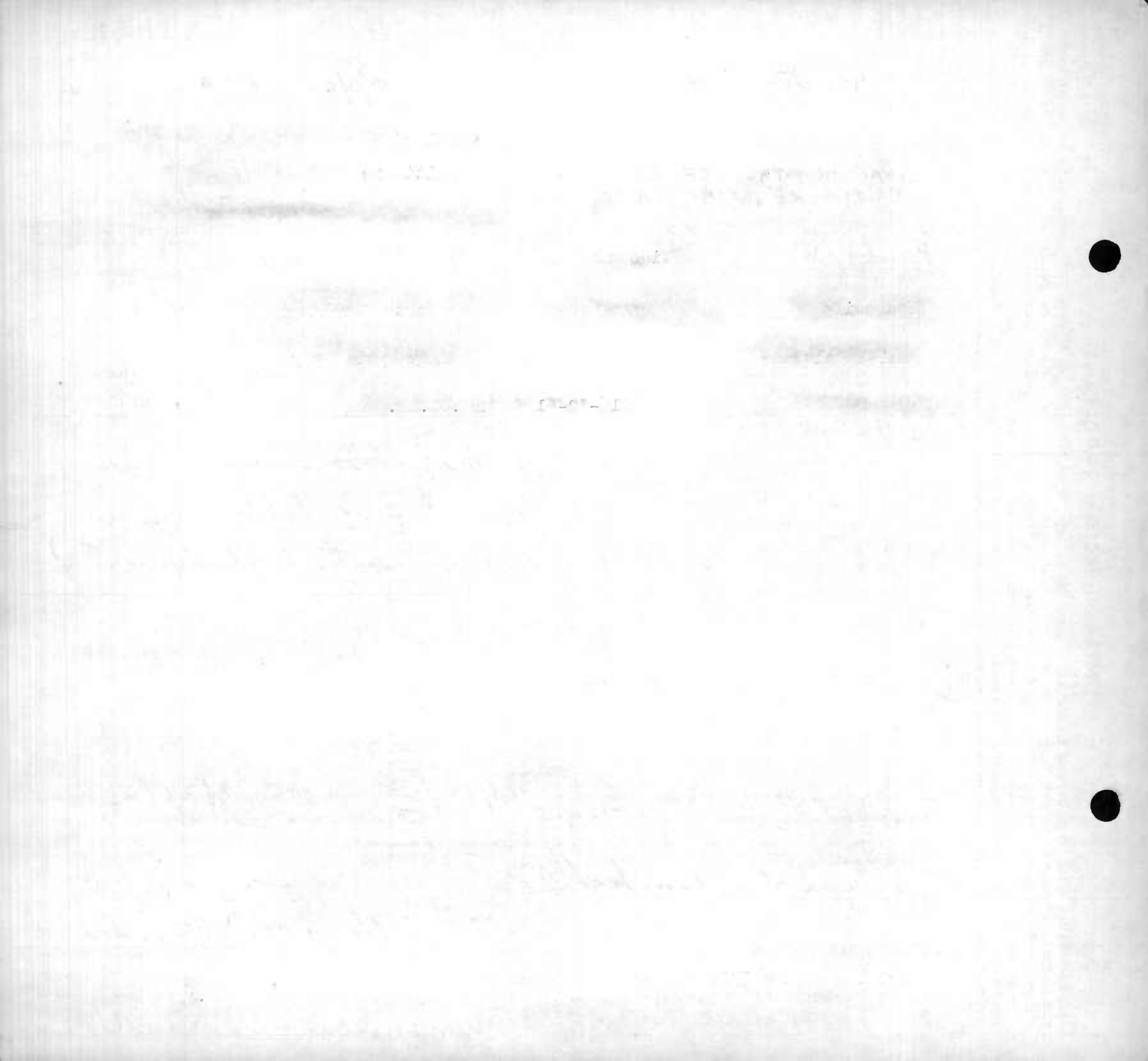
U.S.A.

1954

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <b>65 11051</b>	
BIRTH NO. <b>65 11051</b>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Coltrane VIRGINIA HILL</b>			2. DATE AND HOUR OF DEATH <b>10/26/65 7:42 AM</b> <b>A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY <b>Baltimore</b> (If outside of State, give RURAL and give township) D. STREET ADDRESS (If rural, give location) <b>24613 PARK HEIGHTS AVE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE BALTIMORE, MARYLAND</b>					
5. SEX <b>Female</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9/28/82</b>	9. AGE (In years last birthday) <b>83</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Daniel Coltrane</b>			14. MOTHER'S MAIDEN NAME <b>Mary Lydia Gray</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>216-32-6138</b>	17. INFORMANT <b>Mrs. L. E. Blanchard</b> <b>2308 Beechridge Rd. Raleigh, North Carolina</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420101</b>			CAUSE OF DEATH (A) DUE TO <b>cerebral embolism</b> (B) DUE TO <b>atrial fibrillation</b> (C) <b>atherosclerotic heart disease</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 yrs</b> <b>5 yrs</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/12/65</b> 19 <b>65</b> to <b>10/26/65</b> 19 <b>65</b> , that (we) last saw the deceased alive on <b>10/26/65</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph S. Weinstock</b> M.D.			23B. DATE SIGNED <b>10/26/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Sinai Hosp of Balto., Inc.</b>			23D. ADDRESS <b>Woodlawn, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/27/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION <b>Woodlawn, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Fishman</b>			



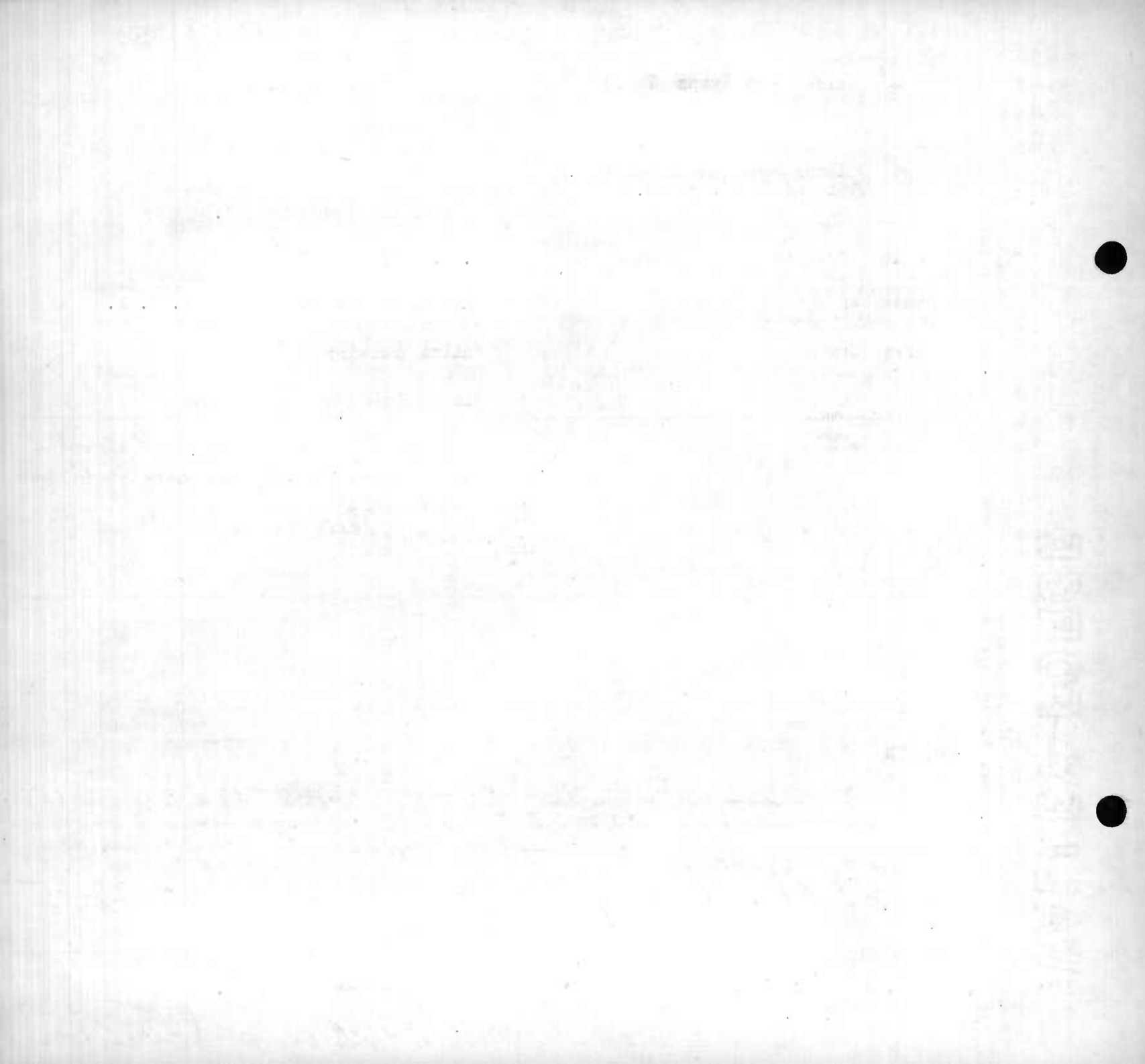


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 11052	
BIRTH NO. 65 11052		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Maude Mary Evans Taylor</b>			2. DATE AND HOUR OF DEATH <b>October 27, 1965</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Uplands Home for Church Women 4501 Old Frederick Rd.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>28-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4501 Old Frederick Rd.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 6, 1873</b>	9. AGE (In years last birthday) <b>92</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Birmingham, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Alfred Evans</b>			14. MOTHER'S MAIDEN NAME <b>Eliza Perkins</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Uplands Home for Church Women</b>		
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <i>Congestive Heart Failure Hypertension 10 yrs. Myocarditis Atherosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>4-5 mos. Gradual onset " "</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Oct 19/1958</b> to <b>Oct 27 1965</b> , that (I) (we) last saw the deceased alive on <b>Oct 25 1965</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <b>10-27-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>M.D.</b>				23D. ADDRESS <b>M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/29/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Vickrey &amp; Sons</b>			
25D. ADDRESS <b>Baltimore, Md. 17</b>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11053				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11053	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) CATHERINE PINKETT		2. DATE AND HOUR OF DEATH 10-25-1965 830 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 211 E. 23rd St				A. STATE B. COUNTY 211 E. 23rd St 12-04			
(If not in hospital or institution, give street address, or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE Md.			
				D. STREET ADDRESS (If rural, give location) 211 E. 23rd St.			
5. SEX FEMALE	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-10-1902	9. AGE (in years last birthday) 63	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY JOHNSON			14. MOTHER'S MAIDEN NAME FLORENCE REYNOLD				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT LILLIAN PINKETT 211 E. 23rd St.			
18. 422.141260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Acute Pulmonary Vascular DUE TO (B) Anterior infarct C.V.D. DUE TO (C) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 1 hour. 3 years. 10 years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 14 1961 to Oct. 25, 1965, that (I) (we) last saw the deceased alive on Oct. 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. A. Silver				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/27/65	
23C. PHYSICIAN'S NAME (Type) A. A. SILVER				23D. ADDRESS TEMPLE GARDENS APT. 3rd fl.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIED		24B. DATE 10-30-65		24C. NAME OF CEMETERY or CREMATORY MT CALVARY		24D. LOCATION (City, town, or county) (State) A.A. COUNTY Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 28 1965		25B. NAME OF REGISTRAR R. E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS JOSEPH KNIGHT 1639 N. BROADWAY			

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65 11054

BALTIMORE CITY HEALTH DEPARTMENT

65 11054

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WINIFRED E. GAILE 2. DATE AND HOUR PRONOUNCED DEAD 10-24-65 8:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Somerset

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Princess Anne 69-00

D. STREET ADDRESS (If rural, give location) UNIVERSITY HOSPITAL

5. SEX Female 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Child 8. DATE OF BIRTH August 29, 1935 9. AGE (In years last birthday) 10 10. UNDER 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) McCready Hos. Crisfield, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Elmer Winifred Gaile 14. MOTHER'S MAIDEN NAME Geraldine Benson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No. 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Elmer W. Gaile - Princess Anne, Md.

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Craniocerebral injuries (A) DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) State Rt. #362 - 1/2 mile West of Princess Anne 69-00

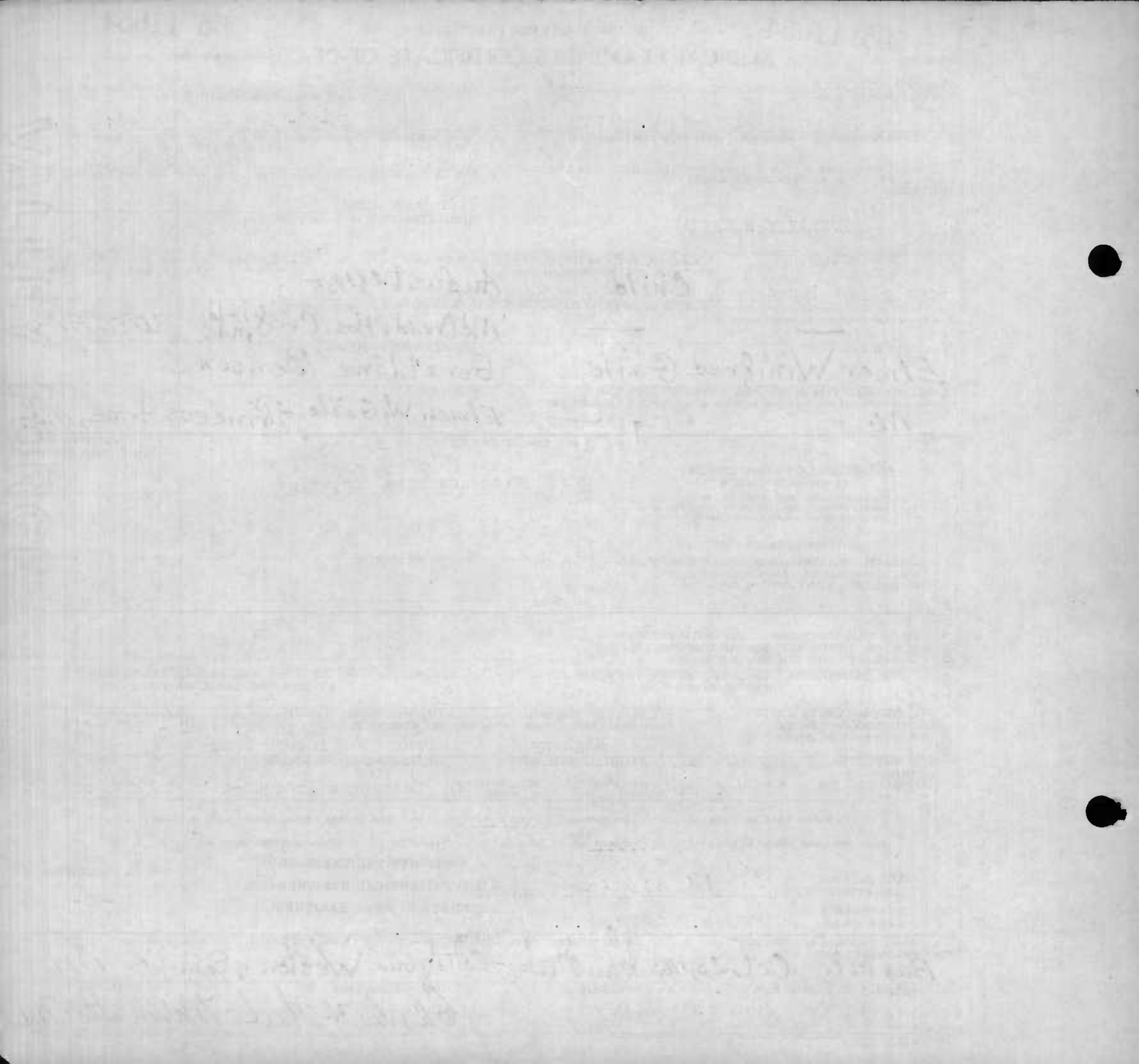
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 10 23 '65 5:40 PM 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK [X] 21F. HOW DID INJURY OCCUR? Passenger in auto-auto collision

22. I certify that I held on Inquiry Inspection Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes Accident [X] Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. CHIEF MEDICAL EXAMINER [X] DATE SIGNED 10-25-65 ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE Oct. 28, 1965 23C. NAME OF CEMETERY or CREMATORY John Wesley - Cottage Grove 23D. LOCATION (City, town, or county) (State) Westover, Som. Co. Md.

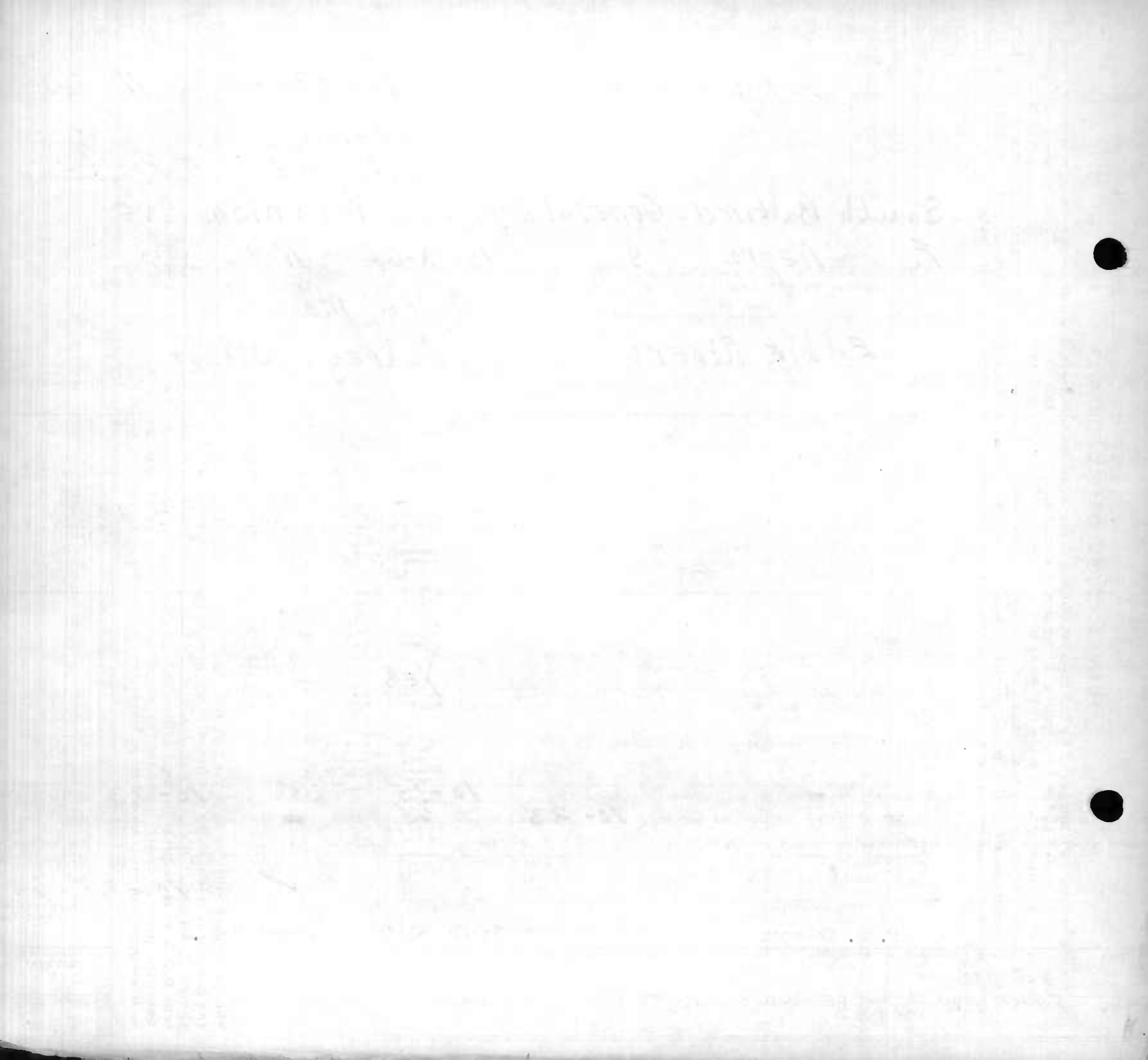
24A. DATE REC'D BY HEALTH DEPT. OCT 28 1965 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS Charles H. Ward - Marion St., Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11055</b>	
BIRTH NO. <b>65-2566765 11055</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Baby Girl Wilson</b>			2. DATE AND HOUR OF DEATH <b>10-23-65 11:30 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-32</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> # <b>21225</b> D. STREET ADDRESS (If rural, give location) <b>1001 Veronica AVE.</b>		
5. SEX <b>F</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>S</b>	8. DATE OF BIRTH <b>10-18-65</b>	9. AGE (In years last birthday) <b>N.B</b>	If Under 1 Yr. Months: Days: Hours: Min. <b>3</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>	
13. FATHER'S NAME <b>Eddie Rivers</b>			14. MOTHER'S MAIDEN NAME <b>Audrey Wilson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <b>763.5 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Immaturity (1-14 Wt)</b>			CAUSE OF DEATH (A) DUE TO <b>Pneumonia</b> (B) DUE TO <b>Immaturity (1-14 Wt)</b> (C) _____		
INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>5 days</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>10-18</b> 19 <b>65</b> to <b>10-23</b> 19 <b>65</b> , that <del>we</del> (we) last saw the deceased alive on <b>10-23</b> 19 <b>65</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Behrooz</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-25-65</b>
23C. PHYSICIAN'S NAME (Type) <b>Dr. M. Behrooz</b>			23D. ADDRESS <b>South Baltimore General Hosp.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>OCT 28 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>JOHNS HOPKINS MEDICAL SCHOOL</b>	
24D. LOCATION (City, town, or county) <b>MARYLAND</b>		24E. (State)		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHO</b>	

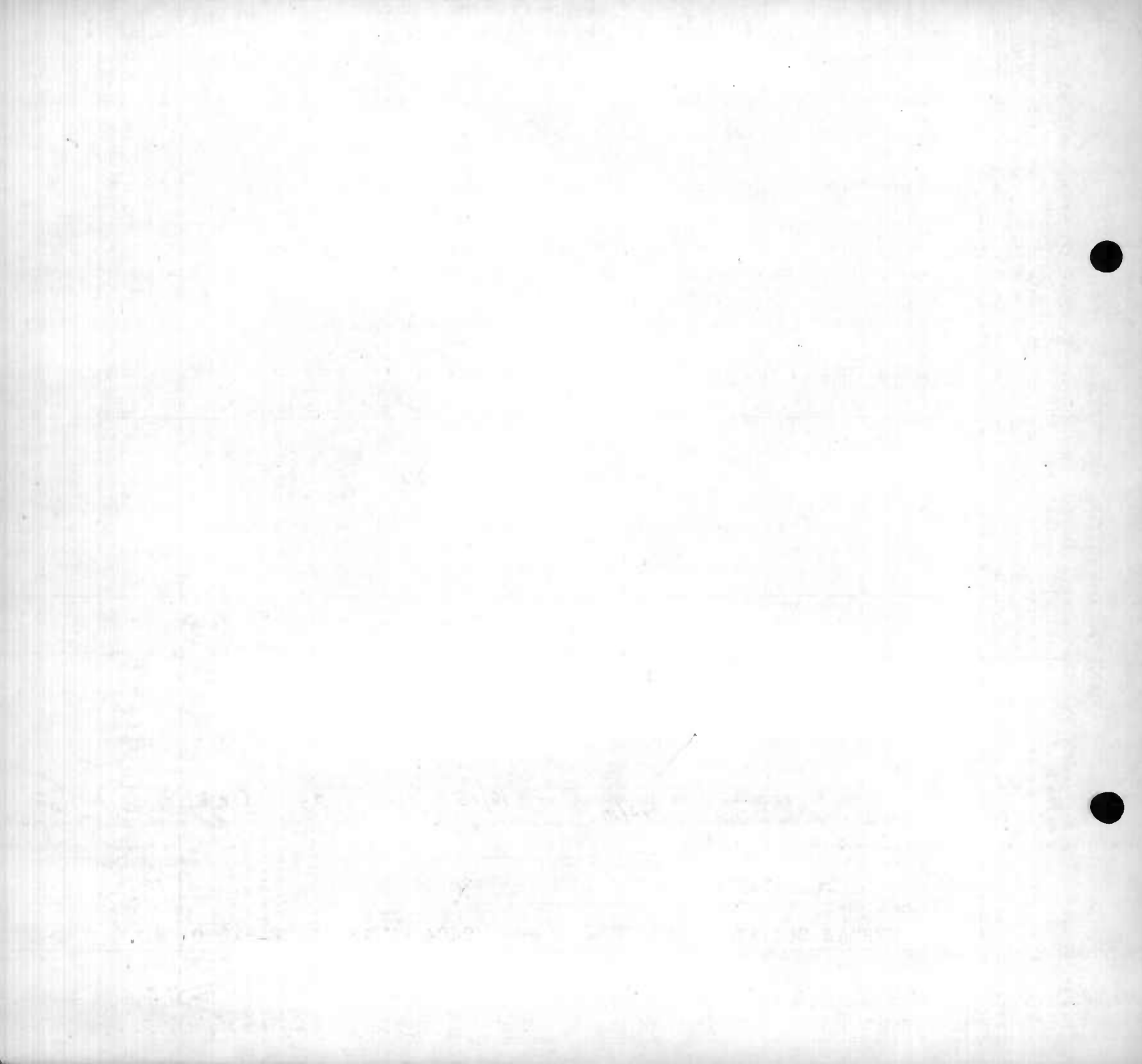




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11056		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11056	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>LEWIS D. TAYLOR</i>		2. DATE AND HOUR OF DEATH <i>OCT 27 - 1965</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2206 W. SARATOGA ST</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>20-02</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>2206 W. SARATOGA ST</i>			
5. SEX <i>M</i>	6. RACE <i>COI</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>JUNE 20 - 1906</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CHAUFFEUR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>TAXICAB</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>ISAAC TAYLOR</i>			
14. MOTHER'S MAIDEN NAME <i>EVA PREE</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>212-094275</i>		17. INFORMANT <i>SUSIE TAYLOR</i> ADDRESS <i>2206 W. SARATOGA ST</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>430.1 I</i>		CAUSE OF DEATH <i>a.s. Hypertensive C.V. Prob. 10-12 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>acute coronary Dec about 1/2 hr</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>chronic nephrosclerosis</i>			
19A. DATE OF OPERATION <i>10/15/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>10/15/65</i> to <i>Oct 26 - 1965</i> , that (I) ( <del>we</del> ) lost saw the deceased alive on <i>10/10/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Herman Seidel</i>		23B. DATE SIGNED <i>10/27/65</i>		23C. PHYSICIAN'S NAME (Type) <i>HERMAN SEIDEL</i>	
23D. ADDRESS <i>2404 EUTAW PLACE-BALTO. MD.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>10/30/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arboretum Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore 21227</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 28 1965</i>		25B. NAME OF REGISTRAR <i>P. D. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Marjorie P. Hays</i>	
25D. ADDRESS <i>638 N. Gilmor St</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11057				BALTIMORE CITY HEALTH DEPARTMENT			
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
Lampe, Edna Mae				OCTOBER 26, 1965 8:35A			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
ST. AGNES HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				PASADENA			
				D. STREET ADDRESS (If rural, give location)			
				LONGPOINT RD. RT 1 BOX 145			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
FEMALE		WHITE		MARRIED		8-10-14	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
51		Housewife		BALTIMORE, MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
EDWARD C. Rodey				ANNA JENKINS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NONE				219-12-3565		ST. AGNES HOSPITAL; CATON & WILKENS AV	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				X KIMMELSTIEL-WILSON			
ANTECEDENT CAUSES				SYNDROME WITH UREMIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from SEPT 25 19 65 to OCT 26 19 65, that (I) (we) lost saw the deceased alive on OCT 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
						10-26-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
P. PURCELL				M.D. ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/28/65		Glen Haven Memorial		Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 28 1965		R. E. Fisher, M.D.		Kirkley Funeral Home		OH	
				Glen Burnie, Md.			

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WB: MEDICAL EXAMINER'S OFFICE  
TO UNIVERSITY HOSPITAL APPROVED OF MEDICAL RECORDS

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11058		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11058	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 65 11058	
1. NAME OF DECEASED (Type or Print) <b>WILLIAM HENRY MILLS</b>		2. DATE AND HOUR OF DEATH <b>24 OCT. 65, 6:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>44</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY</b> <b>38 BALTIMORE MD 71105P</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>52-00</b>			
		D. STREET ADDRESS (If rural, give location) <b>CROWNSVILLE ST. 1105P</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>10/18/1927</b>	9. AGE (In years lost birthday) <b>37</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>GEORGE MILLS</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Self</b> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Renal failure</b>		CAUSE OF DEATH <b>ASCVD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>A</b>	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>24 Sept 1965</b> to <b>24 Oct 1965</b> , that (1) (we) last saw the deceased alive on <b>23 Oct 1965</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard D. Begg</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>24 OCT. 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard D. Begg's D3</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-28-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Richards Cemetery</b>	
24D. LOCATION <b>Egerton Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 28 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>James B. Marshall</b>			
25D. ADDRESS <b>Borbo 6 Calm Md</b>					

[REDACTED]





## CERTIFICATE OF DEATH

Registered No. 65 11059

BIRTH NO.

65 11059

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Ella H. Smith

2. DATE AND HOUR OF DEATH

10-25-1965

1:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Harford

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

(Rural) Havre De Grace

D. STREET ADDRESS (If rural, give location)

331 North Ohio Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

1-8-1901

9. AGE (In years  
lost birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

George Bond

14. MOTHER'S MAIDEN NAME

Linda Dorsey

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 260X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)(A) Renal Failure  
DUE TO

years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) Diabetes  
DUE TO

years

(C) Kimmelstiel Wilson Disease of  
KidneyII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-12- 19 65 to 10-25- 19 65,  
that (I) (we) last saw the deceased alive on 10-25- 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harry Dean Albert

M.D.

Attending  
Phys.☐Med.  
Director☐Staff  
Phys.☒

23B. DATE SIGNED

10-25-1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Harry Dean Albert

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Oct 30, 1965

24C. NAME OF CEMETERY or CREMATORY

Ashbury Methodist Cem.

24D. LOCATION

(City, town, or county)

Churchville, Harford Co.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 28 1965

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Ethel J. Bullock, Havre de Grace, Md.

ADDRESS

21075

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1840

George Lane  
—

George Lane

1840

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11060		BALTIMORE CITY HEALTH DEPARTMENT		31-83-65		65 11060	
M.E. CASE NO.				Registered No.			
1. NAME OF DECEASED (Type or Print) ANNA MARIE STRAN				2. DATE AND HOUR OF DEATH 10/28/65 5:10 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSP REDWOOD + GREENE ST.				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MD. B. COUNTY Balto			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH Nov. 8, 1923	
9. AGE (In years last birthday) 41		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME GEORGE BAKER				14. MOTHER'S MAIDEN NAME CATHERINE ZAK nee Butler			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Morton D. Stran	
18. 199-2-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONIA				CAUSE OF DEATH (A) METASTATIC CARCINOMA DUE TO SITE UNDETERMINED (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ~ 2 1/2 MONTHS TERMINAL	
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (he) (this hospital) attended the deceased from 10/12 19 65 to 10/28 19 65, that (I) (we) last saw the deceased alive on 10/27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fred N. Sugar				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/28/65	
23C. PHYSICIAN'S NAME (Type) FRED N. SUGAR				23D. ADDRESS UNIVERSITY HOSPITAL BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/30/65		24C. NAME of CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REG'D BY HEALTH DEPT. OCT 28 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md.		ADDRESS 21214	

Call Hospital on Birth Date.  
9 m.

10/27/65  
Charles E. [unclear]  
approved and released by medical examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11061		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11061	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ELIZABETH BERGSTRASSER		H.		2. DATE AND HOUR OF DEATH 10/27/65 5:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4409 ASBURY AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married Div.	8. DATE OF BIRTH 5/24/29	9. AGE (In years last birthday) 36	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) I.B.M. Tabulator		10B. KIND OF BUSINESS OR INDUSTRY Western Electric Co.		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Carl Heverly			
14. MOTHER'S MAIDEN NAME Gertrude Johnson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 170-22-1012		17. INFORMANT chart - Union Memorial Hosp			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease or injury at complication which caused death.) meningitis.		INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. MEDICAL EXAMINER'S CASE M.D. CHIEF OR ASST. MEDICAL EXAMINER M.D. [signature]			
22. I certify that (if) (this hospital) attended the deceased from 10/27 1965 to 10/27 1965, and that (we) last saw the deceased alive on 10/27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.		23. SIGNATURE Lawrence J. Lieberman M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED 10/27/65			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/30/65.		24C. NAME OF CEMETERY or CREMATORY Chapel Lawn Memorial Cem.	
24D. LOCATION (City, town, or county) (State) Dallas, Pa.		25. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214			
25A. DATE REC'D BY HEALTH DEPT. OCT 28 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. ADDRESS 21214	

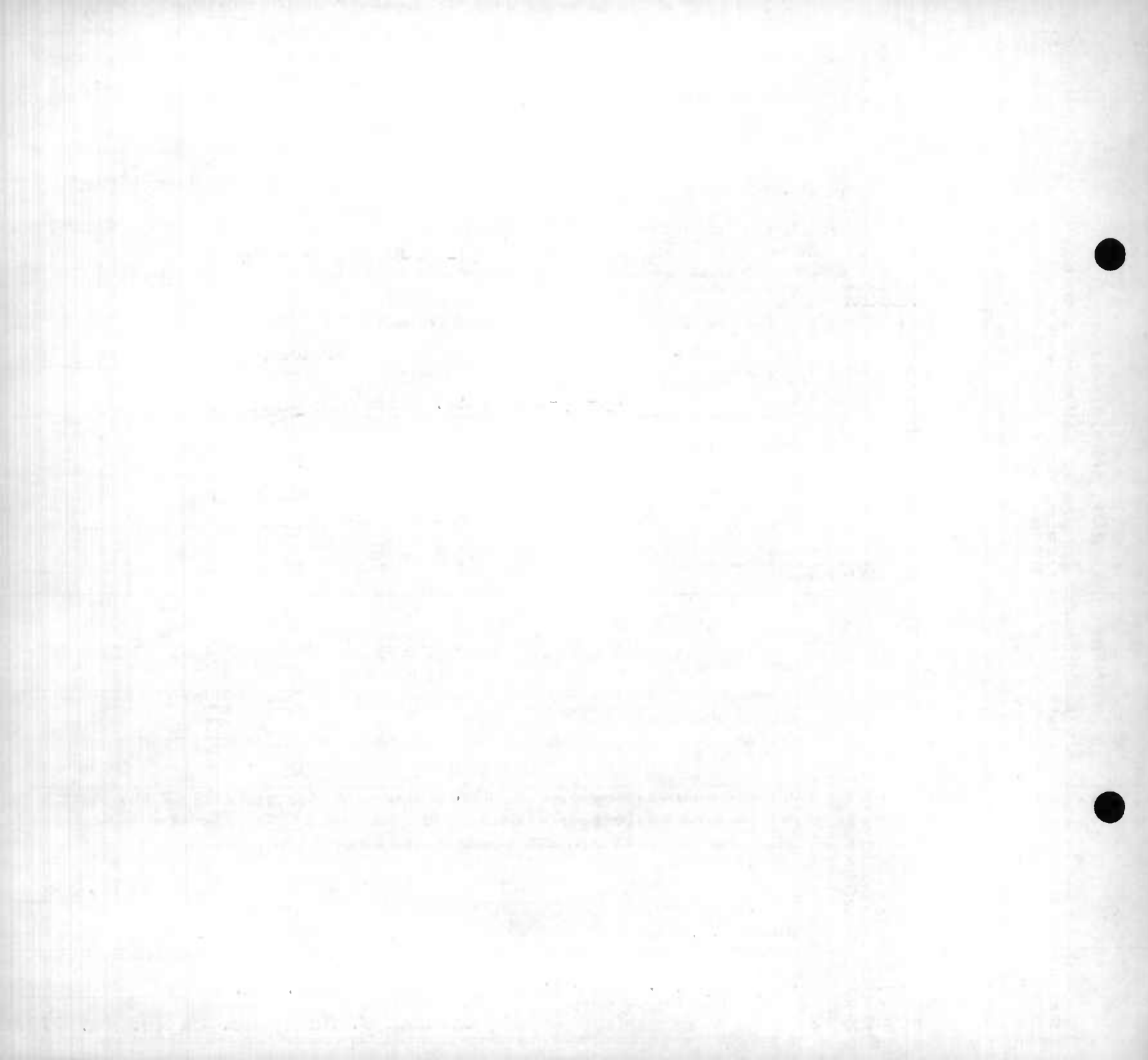
UNION PETROLEUM HOSPITAL

LAWRENCE J. L. HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11062</b>	
65 11062 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WALKOWICZ, JOHN		October 28, 1965 1:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
St. Joseph Hospital			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore 21214		
			D. STREET ADDRESS (If rural, give location)		
			3007 Pinewood Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	Widowed	12-15-80	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Tailor				Poland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		215-03-8682		Mrs. Adelpia Gabriel Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from October 23, 1965 to October 28, 1965, that (I) (we) last saw the deceased alive on October 28, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Alphonso Y. S. Rhee M.D.				October 28, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Alphonso Y. S. Rhee		1400 N. Caroline Street - 21213			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	10/30/65	St. Stanislaus Cemetery		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 28 1965		R. E. Farkley, M.D.		Leonard J. Ruck, Inc., Balto., Md. 21214	

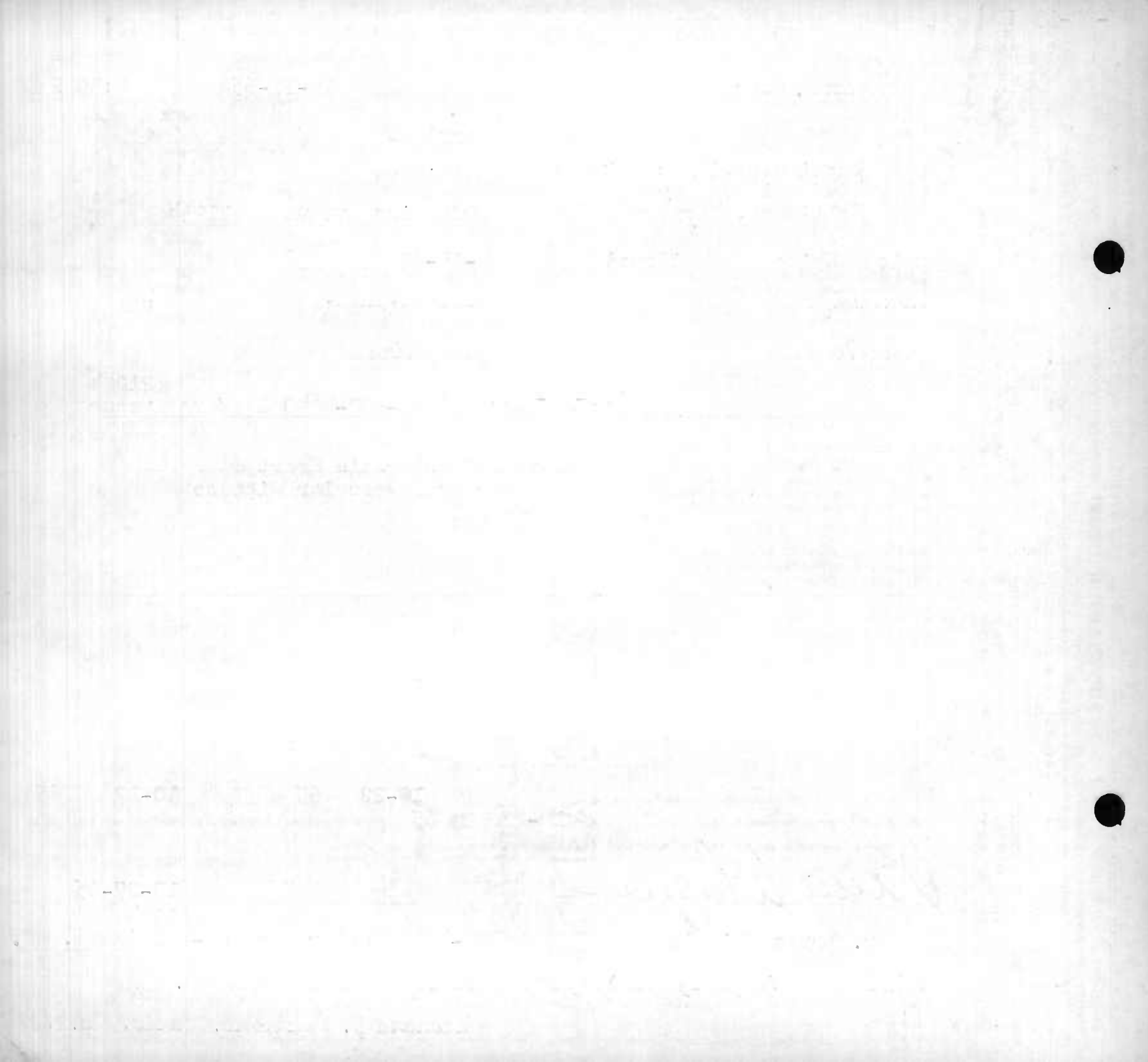




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

45-02-133 IE K-20A		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11063	
BIRTH NO. 65 11063		CERTIFICATE OF DEATH		Registered No. 65 11063	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Anna Kosar		2. DATE AND HOUR OF DEATH 10-27-65 4:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2929 Hiss Avenue #21234			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-11-67	9. AGE (In years last birthday) 98	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Tomiska		14. MOTHER'S MAIDEN NAME Josephine ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 278-52-2961		17. INFORMANT #21224 RECORDS-BCH-4940 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Arteriosclerotic Heart & Cerebral Vascular Disease (B) Old age (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netly medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-22-1965 to 10-27-1965, that (I) (we) last saw the deceased alive on 10-27-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Bruce Whipple		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-27-65	
23C. PHYSICIAN'S NAME (Type) Dr. Bruce Whipple		23D. ADDRESS #21224 BCH-4940 Eastern Avenue-Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/30/65	24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 28 1965	25B. NAME OF REGISTRAR R. E. Feltner	25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md.		ADDRESS 21214	



BIRTH NO. 65 11064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11064

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARION BRICKER

2. DATE AND HOUR PRONOUNCED DEAD

October 26, 1965 5:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

521 Harwood Avenue.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

April 27, 1905

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

? BYLL

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

?

17. INFORMANT

Dorothy Heppner

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 27, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-29-65

23C. NAME of CEMETERY or CREMATORY

Western

23D. LOCATION (City, town, or county) (State)

Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.

OCT 29 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

GEO. L. Schwab Funeral Home  
Francis H. Miller 2101 Frederick Ave.

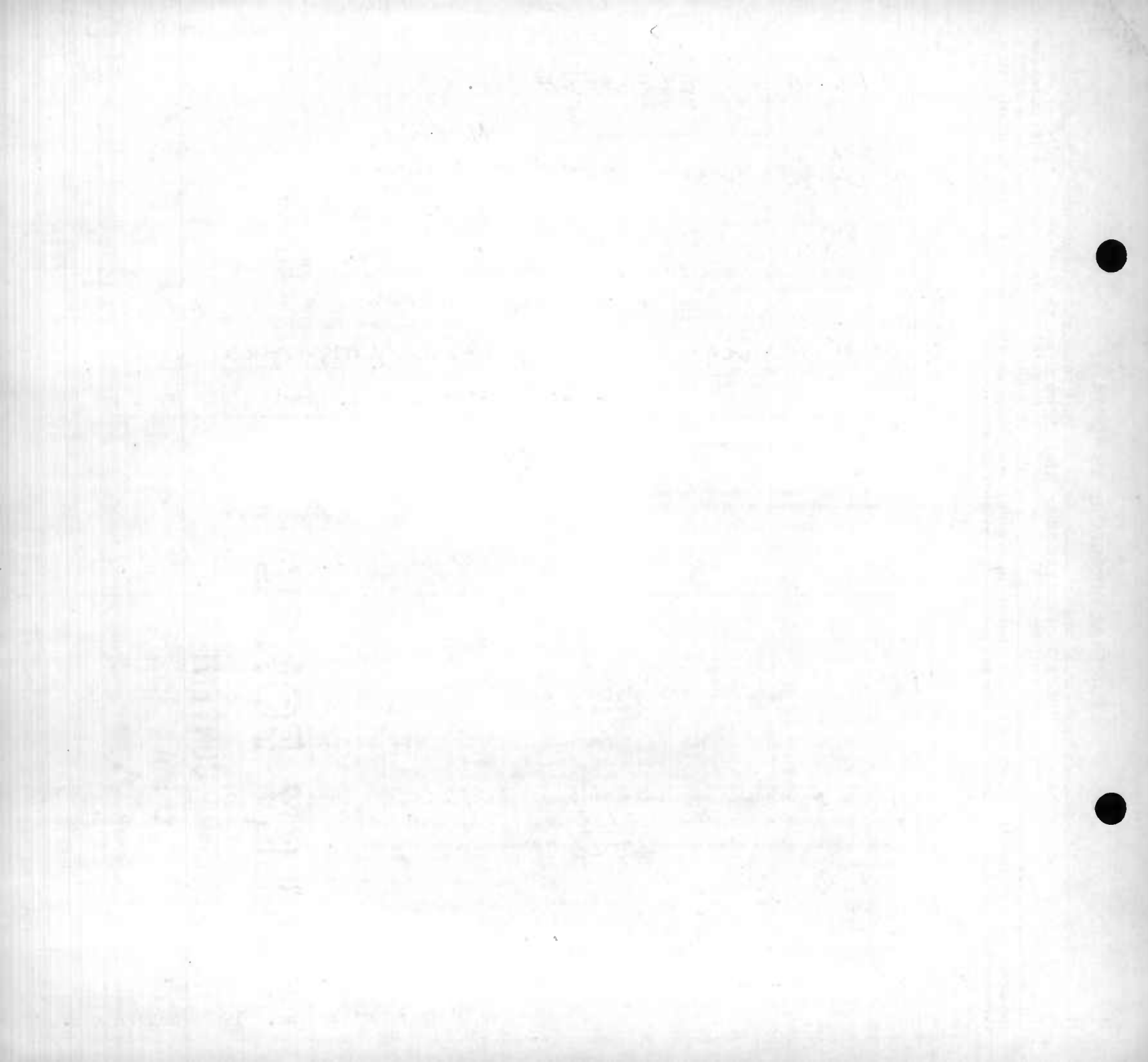
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11065		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11065	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ELFREIDA F. HORNIG</b> <b>HORNIG, ELFRIEDA</b>		2. DATE AND HOUR OF DEATH <b>10/28/1965</b> <b>9 32 a.m.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>North Charles General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>H&amp;Y</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2535 Fait Ave</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>2/10/1902</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Lord Baltimore Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Nat. Citizen</b>		13. FATHER'S NAME <b>Rinehart Hornig</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Nurgerbauer</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-0757</b>		17. INFORMANT <b>Miss Martha A. Hornig</b> ADDRESS <b>2535 Fait Avenue</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>I</b> <b>Generalized Carcinomatosis</b> <b>Secondary to advanced carcinoma of the stomach</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION <b>11/02/765</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca 2 stomach with metastases</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>10/20</b> 19 <b>65</b> to <b>10/28</b> 19 <b>65</b> , that (we) lost saw the deceased alive on <b>10/28</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George Hebe</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/28/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. E. T. HOPKINS</b>		23D. ADDRESS <b>205 W. Lanvale St - Balt-Md -</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-30-1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Seiler Inc. 1901 Eastern Ave.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11066	
BIRTH NO. 65 11066				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Martha Taylor</u>			2. DATE AND HOUR OF DEATH <u>10/25/65</u> <u>1:58 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Bolton</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Bolton Ave. Reisterstown</u> D. STREET ADDRESS (If rural, give location) <u>Bolton Ave</u> <u>5300</u>		
5. SEX <u>♀</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8/25/16</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <u>U.S.A. - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Stewart</u>			14. MOTHER'S MAIDEN NAME <u>Fannie Griffin</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-50-1179</u>	17. INFORMANT <u>Charles L. Taylor</u> ADDRESS <u>Bolton Ave., Reisterstown Md.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>053,414260X</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Pseudomonas septicaemia</u> DUE TO (B) <u>Urinary and pulmonary infections</u> DUE TO (C) —		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>diabetes, hypertension, cerebral artery thrombosis</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>9/25</u> 19 <u>65</u> to <u>10/25</u> 19 <u>65</u> , that (I) <u>we</u> last saw the deceased alive on <u>10/25</u> 19 <u>65</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jonathan J. Ingle</u> M.D.				23B. DATE SIGNED <u>10/25/65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Oct. 28, 1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Luke's Meth. Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Reisterstown, Maryland.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 29 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. J. Echhardt</u> ADDRESS <u>Owings Mills, Md.</u>			





65 11067

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 11067

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN E. KEIMIG

2. DATE AND HOUR PRONOUNCED DEAD

10/27/65 3:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Riviera Beach

D. STREET ADDRESS (If rural, give location)

232 Kenwood Ave. Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1/17/1921

9. AGE (In years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maintenance man

10B. KIND OF BUSINESS OR INDUSTRY

Weiskittel Factory

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Keimig

14. MOTHER'S MAIDEN NAME

Drene Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)

WW II Navy

16. SOCIAL SECURITY NO.

218-01-4018

17. INFORMANT

Celeste Keimig

ADDRESS

Above

18. E 912.13

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral injury  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

factory

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Weiskittel - 4901 Pulaski Hwy.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10 27 65 3:12p

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

was caught in machine

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/28/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/1/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION (City, town, or county) (State)

5301 Frederick Ave Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 29 1965

24B. NAME OF REGISTRAR

E. Farber, M.D.

24C. FUNERAL DIRECTOR

John J. Cowan &amp; Son Inc. 901 St. Hollings 23, Md.

# VALLEY FOLIO

VALLEY FOLIO

17

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">65 11068</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 1.5em;">65 11068</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ADAMS, EDWARD			10-26-65		4:30 PM
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  ST AGNES HOSPITAL			A. STATE MARYLAND		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 2427 BRUNSWICK ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	B. DATE OF BIRTH 8-22-95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME LEWIS			14. MOTHER'S MAIDEN NAME VIOLET SMITH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 215-01-3049	17. INFORMANT CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKINS AND		
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
I Probable pulmonary embolism Severe malnutrition					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-21-19 65 to 10-26-19 65, that (I) (we) last saw the deceased alive on 10-26-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carmen Fratto				23B. DATE SIGNED 10/26/65	
23C. PHYSICIAN'S NAME (Type) CARMEN FRATTO				23D. ADDRESS ST AGNES HOSPITAL, BALTO. 29, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-30-65		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEM	
24D. LOCATION DUNDALK		24E. CITY, town, or county MD.		24F. STATE MD.	
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1965		25B. NAME OF REGISTRAR P. E. Farley		25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC. 401 S. CHESTER ST	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11069		BALTIMORE CITY HEALTH DEPARTMENT		85 11069	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) (Rose) Rozalia Mazur		2. DATE AND HOUR OF DEATH 10-27-65 3:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		A. STATE Md. B. COUNTY Balto			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex		53-00			
D. STREET ADDRESS (If rural, give location) 323 Oberlin Ave.					
5. SEX Fe	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Dec 22-1887	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY At-Home	11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? yk. S. G.
13. FATHER'S NAME Matenay Zybiruw		14. MOTHER'S MAIDEN NAME Dabek		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Leon Mazur (Husband)		ADDRESS Same	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-27 1965 to 10-27 19 65, that (I) (we) last saw the deceased alive on 10-27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. D. Kreider		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-27-65	
23C. PHYSICIAN'S NAME (Type) Dr. S. D. Kreider		23D. ADDRESS BCH-4940 Eastern Avenue-Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/30/65		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cem	
24D. LOCATION Balto		24E. LOCATION (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1965		25B. NAME OF REGISTRAR Robert E. Finken		25C. FUNERAL DIRECTOR Connelly F.H. 300 Mass	

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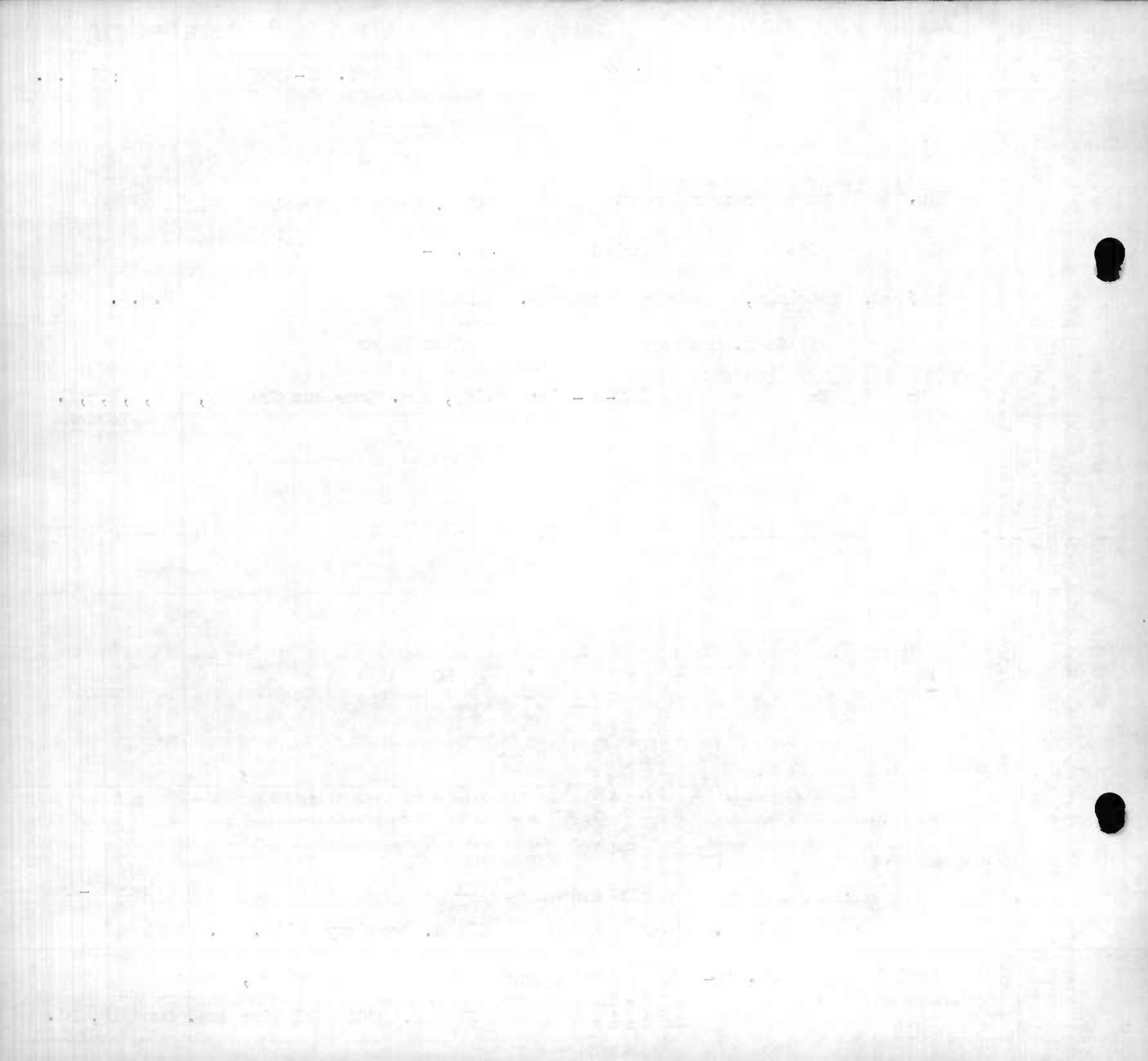
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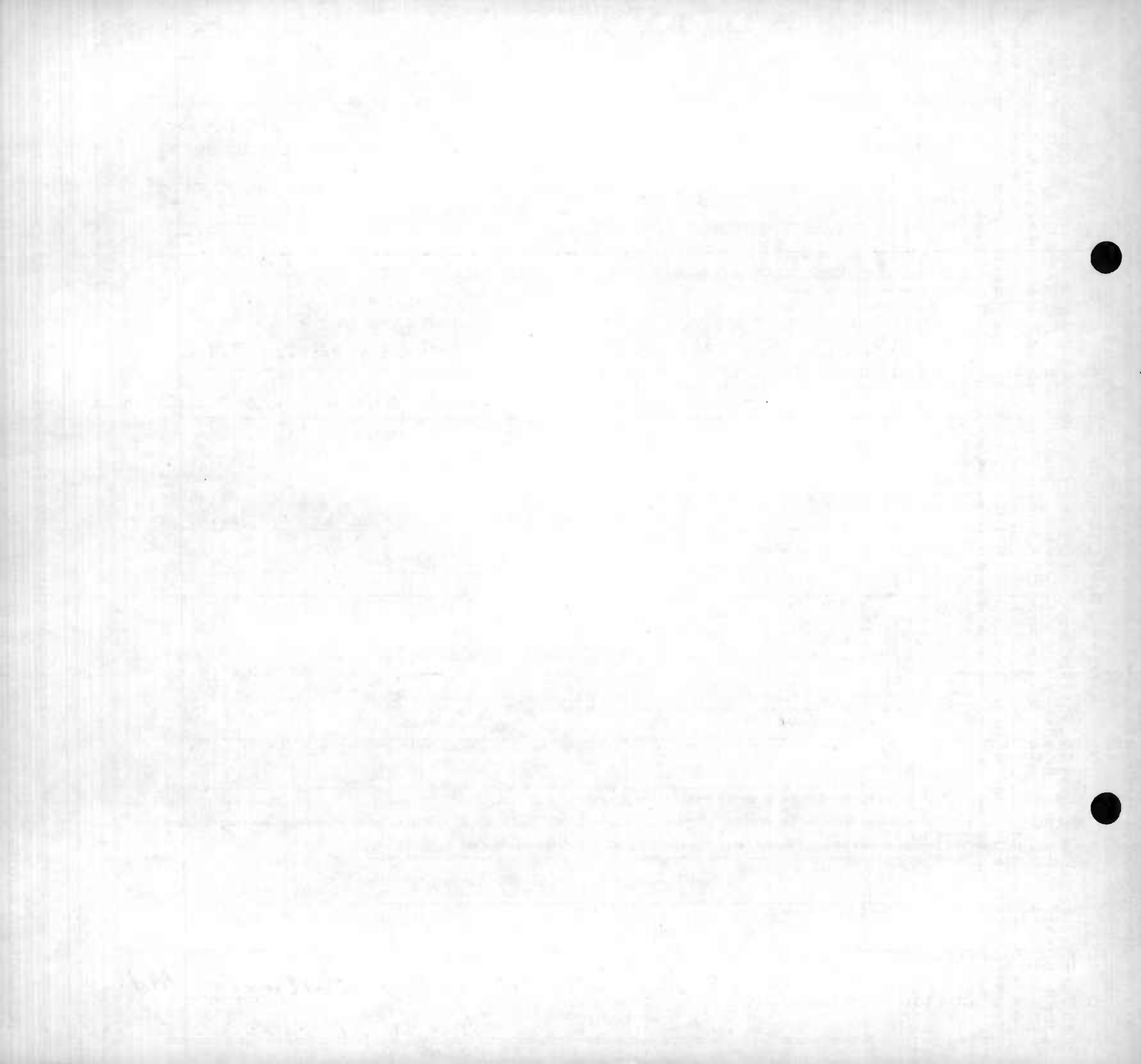
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11070</b>	
BIRTH NO. <b>65 11070</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM GREGORY</b>		2. DATE AND HOUR OF DEATH <b>Oct. 28-1965</b> <b>2:30 a.m.</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b> B. COUNTY <b>26-44</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location)		<b>23 N. Kresson Street 21224</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Married</b>	8. DATE OF BIRTH <b>Jan. 9-1894</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Watchman,</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>American Scrap Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Willie C. Gregory</b>			
14. MOTHER'S MAIDEN NAME <b>Ellen Haden</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>287-09-9421</b>		17. INFORMANT ADDRESS <b>Wife, Mrs. Loureena Gregory, # 4, a, b, c, d.</b>			
18. <b>332X I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) <b>CEREBRAL THROMBOSIS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 19 60</b> to <b>OCT. 28 19 65</b> , that (I) <del>was</del> lost saw the deceased alive on <b>OCT. 26 19 65</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) view the body after death.					
23A. SIGNATURE <b>Irvin B. Kaplan</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>October 28-1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Irvin B. Kaplan</b>		23D. ADDRESS <b>M.D. 129 S. Broadway Balto. Md. 21231</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 30-1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Memorial Burial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Wheelerburg, Ohio</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 21222</b>			



# FUNERAL DIRECTOR: IMPORTANT

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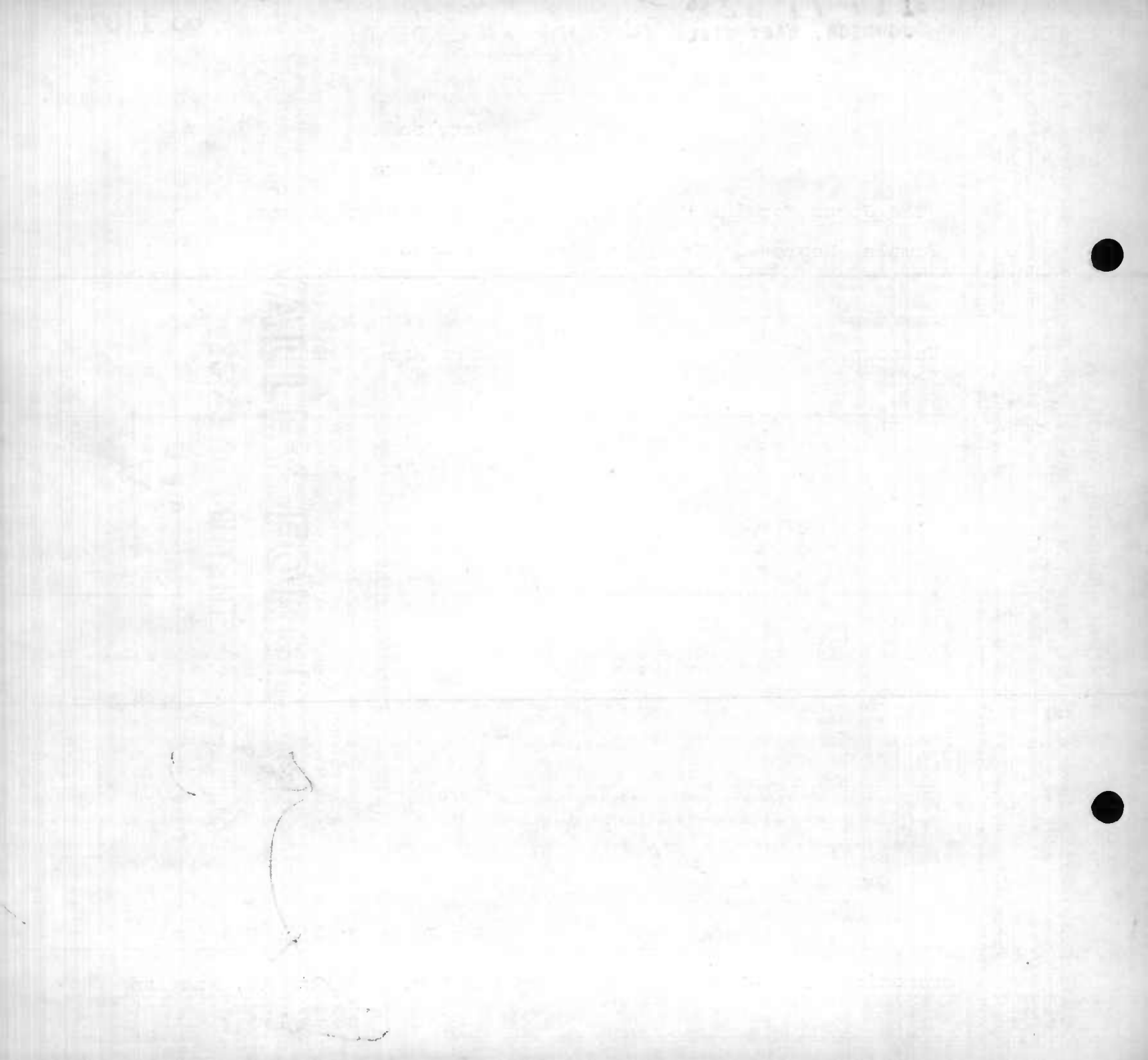
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11071</b>	
BIRTH NO. <b>65 11071</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ETHEL STAVROS</b>		2. DATE AND HOUR OF DEATH <b>10/26/65 6:40 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 26-07</b>			
		D. STREET ADDRESS (If rural, give location) <b>412 S. Lehigh STREET</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3-1-1893</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>PATRICK TIMOTHY FEEHLY</b>			14. MOTHER'S MAIDEN NAME <b>MARY CATHERINE ZOEHLER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT ADDRESS <b>GEORGE STAVROS, 412 S. Lehigh ST.</b>		
18. <b>260 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>SEPTICEMIA</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>CHRONIC BILATERAL LEG ULCERS</b> DUE TO		<b>2 YEARS</b>	
		(C) <b>DIABETES MELLITUS</b>		<b>(?)</b>	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-4-65</b> to <b>10-26-65</b> , that (I) (we) last saw the deceased alive on <b>Oct 24 10-26-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Eusebio P. Gonzalez M.D.</b>				23B. DATE SIGNED <b>10/26/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>EUSEBIO P. GONZALEZ M.D.</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10/29/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Nicholas T. MATTHEWS, 3021 EASTERN AVE. #24</b>	



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BIRTH NO. JOHNSON, BABY GIRL 1072				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11072	
1. NAME OF DECEASED (Type or Print) <b>Baby Girl Johnson</b>				2. DATE AND HOUR OF DEATH <b>10/26/65</b> <b>2:12 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>10-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1039 Central Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, NEVER MARRIED</b>		8. DATE OF BIRTH <b>10-26-65</b>	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: <b>1</b> Days: <b>1</b> Hours: <b>1</b> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Edna Mae Johnson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <b>776 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Im maturity</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Im maturity</b> DUE TO (B) <b>Im maturity</b> DUE TO (C) <b>Im maturity</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/26/65</b> <b>19 65</b> to <b>10/26/65</b> <b>19 65</b> , that (I) (we) last saw the deceased alive on <b>10/26/65</b> <b>19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Herbert Kaiser</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>10/26/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Herbert Kaiser</b>				23D. ADDRESS M.D. <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>cremation</b>	24B. DATE <b>10-26-65</b>	24C. NAME of CEMETERY or CREMATORY <b>The John Hopkins Hos.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fickel</b>		25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>		ADDRESS	

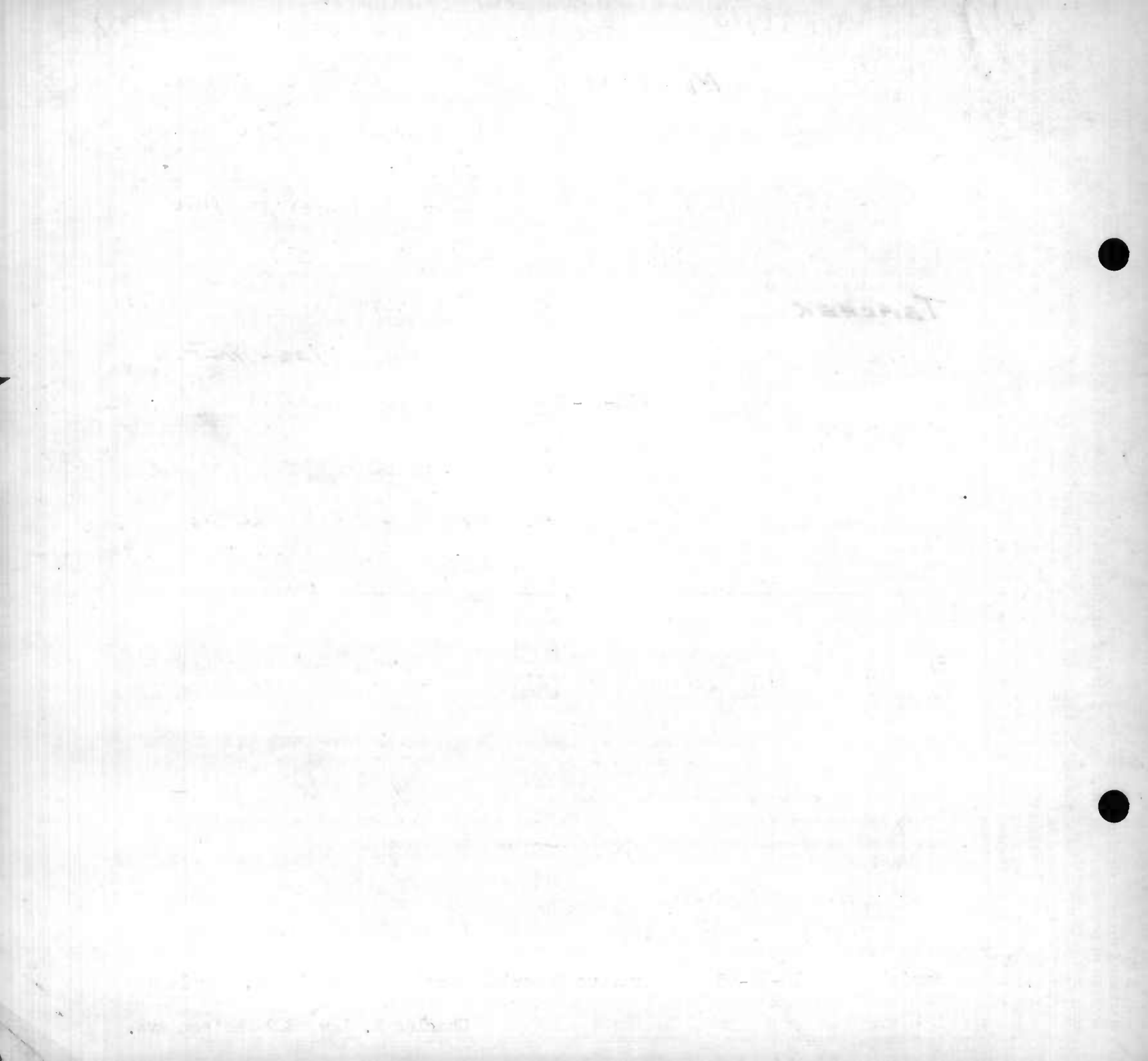


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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11073</b>	
BIRTH NO. <b>65 11073</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>OCTOBER 27, 1965 8:00 P.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>KATHLEEN M. PARKER</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 5-3-00</b>	
		D. STREET ADDRESS (If rural, give location) <b>2006 NORTHEAST AVE.</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5/30/08</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <b>57</b>
13. FATHER'S NAME <b>PHILLIP STEVENSON</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. MOTHER'S MAIDEN NAME <b>NANNIE WASHINGTON</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT ADDRESS <b>HUSBAND - HERMAN L. PARKER S/A</b>	
16. SOCIAL SECURITY NO. <b>214-40-8304</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>INTRACEREBRAL HEMORRHAGE 3 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ANEURYSM L. PERICALLOSAL ARTERY</b>		(B) DUE TO <b>THROMBOSIS RT CAROTID ARTERY</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>10/19/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RT. CAROTID OCCLUSION</b>	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>-</b>			
22. I certify that (X) (this hospital) attended the deceased from <b>10/14</b> 19 <b>65</b> to <b>10/27</b> 19 <b>65</b> , that (X) (we) last saw the deceased alive on <b>10/27</b> 19 <b>65</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>IRWAN L. BUTLER</b>		23B. DATE SIGNED <b>10/27/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>IRWAN L. BUTLER</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-30-65</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave.</b>	





65 11074

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 11074

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

P.

CHARLES WALKER

2. DATE AND HOUR PRONOUNCED DEAD

October 27, 1965

unknown M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

711 Dolphin Street

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

3-3-1908

9. AGE (in years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Merchant Seaman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maxton, N. C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Walker

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
219-01-0958

17. INFORMANT ADDRESS

Lila McClain - 2810 Edmondson Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Oct. 27, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10-30-65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

OCT 29 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Charles R. Law

ADDRESS

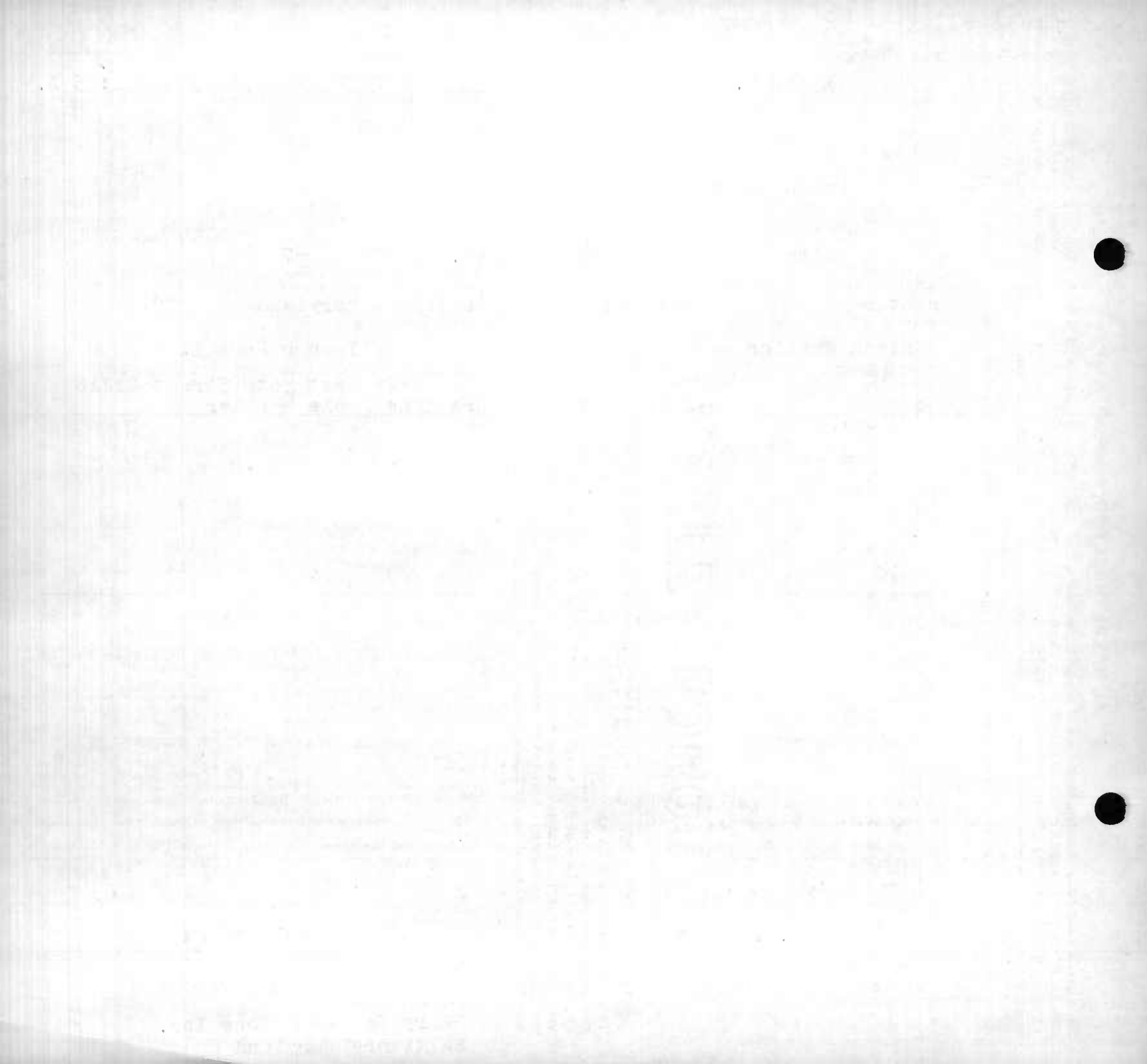
802 Madison Ave.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11075		CERTIFICATE OF DEATH		Registered No. 65 11075	
1. NAME OF DECEASED (Type or Print) <b>ELMER P. WHEELER</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 27, 1965 1:15 A. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-03</b>					
5. SEX <b>Male</b>				6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>Dec. 23, 1897 67</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nelson Wheeler</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor Pursell</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no 212 01 4943</b>				16. SOCIAL SECURITY NO. <b>4943</b>		17. INFORMANT ADDRESS <b>723 East 36th Street 21218</b> <b>Mrs Mina Poole Wheeler</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b>				CAUSE OF DEATH (A) <b>Acute myocardial infarction</b> DUE TO (B) <b>ASCHVD</b> DUE TO (C) <b>ASCHVD</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4/24/63</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>I. W. Fromm</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/28/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>I. W. Fromm</b>				23D. ADDRESS M.D. <b>1123 Saint Paul Street</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/30/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Fairman</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Henry Sander &amp; Sons Inc.</b> <b>Baltimore, Maryland</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 11076</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11076</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MRS. ANNA GERTRUDE SCHARF</b>		2. DATE AND HOUR OF DEATH <b>10/26/65 1040 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 29 33-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BON SECOURS HOSPITAL</b>		D. STREET ADDRESS (If rural, give location) <b>638 1/2 PLYMOUTH RD.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3/25/14</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Roofing Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Harry M. Weaver</b>		14. MOTHER'S MAIDEN NAME <b>Marie E. Straser</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215 09 8772</b>		17. INFORMANT <b>Edward M. Scharf</b>	
				ADDRESS <b>638 1/2 Plymouth Rd</b>	
18. <b>171X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Chemia + carcinomatosis</b> DUE TO (B) <b>tx of cervix</b> DUE TO (C) <b>tx of cervix</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>11-13-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>exploratory laparotomy "Cervix"</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 23 1965</b> to <b>Oct 26 1965</b> , that (I) (we) last saw the deceased alive on <b>October 26 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jaime Acci-Nellci</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-26-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAIME-ACCINELLI</b>		23D. ADDRESS <b>Bon Secours Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/29/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Plk</b>	
24D. LOCATION <b>Baeto. 7. Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzger, W. H. 4101 E. ...</b>	
				ADDRESS <b>...</b>	

THE STATE OF NEW YORK

IN SENATE

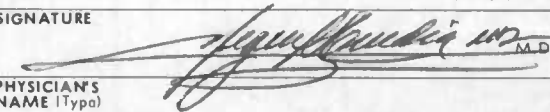
JANUARY 1, 1901

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 1, 1901



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 11077	
BIRTH NO. 65 11077		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) O'CONNELL, JOSEPH J.			2. DATE AND HOUR OF DEATH 10-28-65 1:55A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 29 D. STREET ADDRESS (If rural, give location) 4505 MANORDENE ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 10-12-83	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Comptroller, Hochschule		10B. KIND OF BUSINESS OR INDUSTRY Kohn o.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN O'CONNELL			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME NELLIE DALY
17. INFORMANT ST. AGNES RECORDS - CATON & WILKENS AVES			ADDRESS		
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) MASSIVE PULMONARY INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 16 19 65 to OCTOBER 28 19 65, that (I) (we) last saw the deceased alive on OCTOBER 28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 10-28-65		23C. PHYSICIAN'S NAME (Type) M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) burial			24B. DATE 10/30/65		24C. NAME of CEMETERY or CREMATORY New Cathedral
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1965			25B. NAME OF REGISTRAR R. E. Barker, M.D.		25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave.
24D. LOCATION (City, town, or county) Baltimore 29, Md.			24E. ADDRESS		

10-11-1961

10-11-1961

ST. AGNES HOSPITAL

10-11-1961

THE WHITE

10-11-1961

ST. AGNES HOSPITAL

10-11-1961

ST. AGNES HOSPITAL

10-11-1961

10-11-1961

10-11-1961

10-11-1961

10-11-1961

10-11-1961

10-11-1961

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11078		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11078	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Sophie E. Lang</b>			2. DATE AND HOUR OF DEATH <b>Oct. 27/65</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>22 S. Athol Ave</b> <b>General German Aged Peoples Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ma</b> B. COUNTY <b>28-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>22 S. Athol Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>March 11/87</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Gotfried L. Lang</b>			14. MOTHER'S MAIDEN NAME <b>Elise K. ---</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Records, German Home 22 S. Athol Ave</b>		
18. <b>433.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>atherosclerotic Myocardial</b> DUE TO (B) <b>regeneration &amp; chronic</b> DUE TO (C) <b>failure &amp; acute arrhythmia</b> <b>causing death</b>  INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>0</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1964</b> to <b>27 Oct 1965</b> , that (I) (we) last saw the deceased alive on <b>27 Oct 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William E. Bryson</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>28 Oct 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>William E. Bryson</b>		23D. ADDRESS <b>4605 Edmondson Ave</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>burial</b>	24B. DATE <b>10/30/65</b>	24C. NAME of CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. 7, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jankowski</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke F.D. 4101 Edmondson Ave</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11079</b>	
BIRTH NO. <b>65 11079</b>				CERTIFICATE OF DEATH	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Fannie Mae McQuilkin</b>			2. DATE AND HOUR OF DEATH <b>Oct. 27/65</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>5109 Brook Green Road</b>			A. STATE <b>Md.</b> B. COUNTY <b>28-04</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>5109 Brook Green Rd</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Married</b>	8. DATE OF BIRTH <b>May 6/83</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George W. Snyder</b>			
14. MOTHER'S MAIDEN NAME <b>Mary C. Richards</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Howard P. McQuilkin, 5109 Brook Green rd</b>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) <b>Coronary occlusion</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>interossealactic cardiovascular disease</b> DUE TO		<b>1 yr +</b>
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this <del>hospital</del> ) attended the deceased from <b>December 25</b> 19 <b>51</b> to <b>Oct 27</b> 19 <b>65</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Oct 25</b> 19 <b>65</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>John A. Nesbitt, Jr.</b>				23B. DATE SIGNED <b>10-28-65</b>	
M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					
23C. PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR.</b>		23D. ADDRESS <b>1009 Frederick Rd, Baltimore Md 21228</b>			
23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>10/29/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Ridge</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville 8, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jakes</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D. 4101 Edmondson Ave</b>	

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1. The first part of the document

describes the general situation

and the main objectives of the project.

The second part of the document

describes the methodology used in the study.

The third part of the document

describes the results of the study.

The fourth part of the document

describes the conclusions of the study.

The fifth part of the document

describes the recommendations of the study.

The sixth part of the document

describes the references of the study.

The seventh part of the document

describes the appendix of the study.

65 11080		BALTIMORE CITY HEALTH DEPARTMENT		65 11080	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		FLORENCE EDWARDS		October 27, 1965 5:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY	
Provident Hospital		Connecticut		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		New Haven		D. STREET ADDRESS (If rural, give location)	
		211 Newhall Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
female	negro	MARRIED	8/18/37	38	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk		Hospital		S Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Rev James McDaniel		Julia Belton		U S A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Mrs Roberta Roberts 2825 Woodbrook Ave	
18. 3-8-10 I		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Bronchopneumonia DUE TO fatty liver			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		October 27, 1965	
Rudiger Breitenecker, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		10/30/65		Sumpter	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
00012991-1965		R. E. J. F. J. J. J.		Adolphus Halstead 1206 W North Ave	
				South Carolina	



WILLIAM H. BORGES

LAURENCE J. BORGES

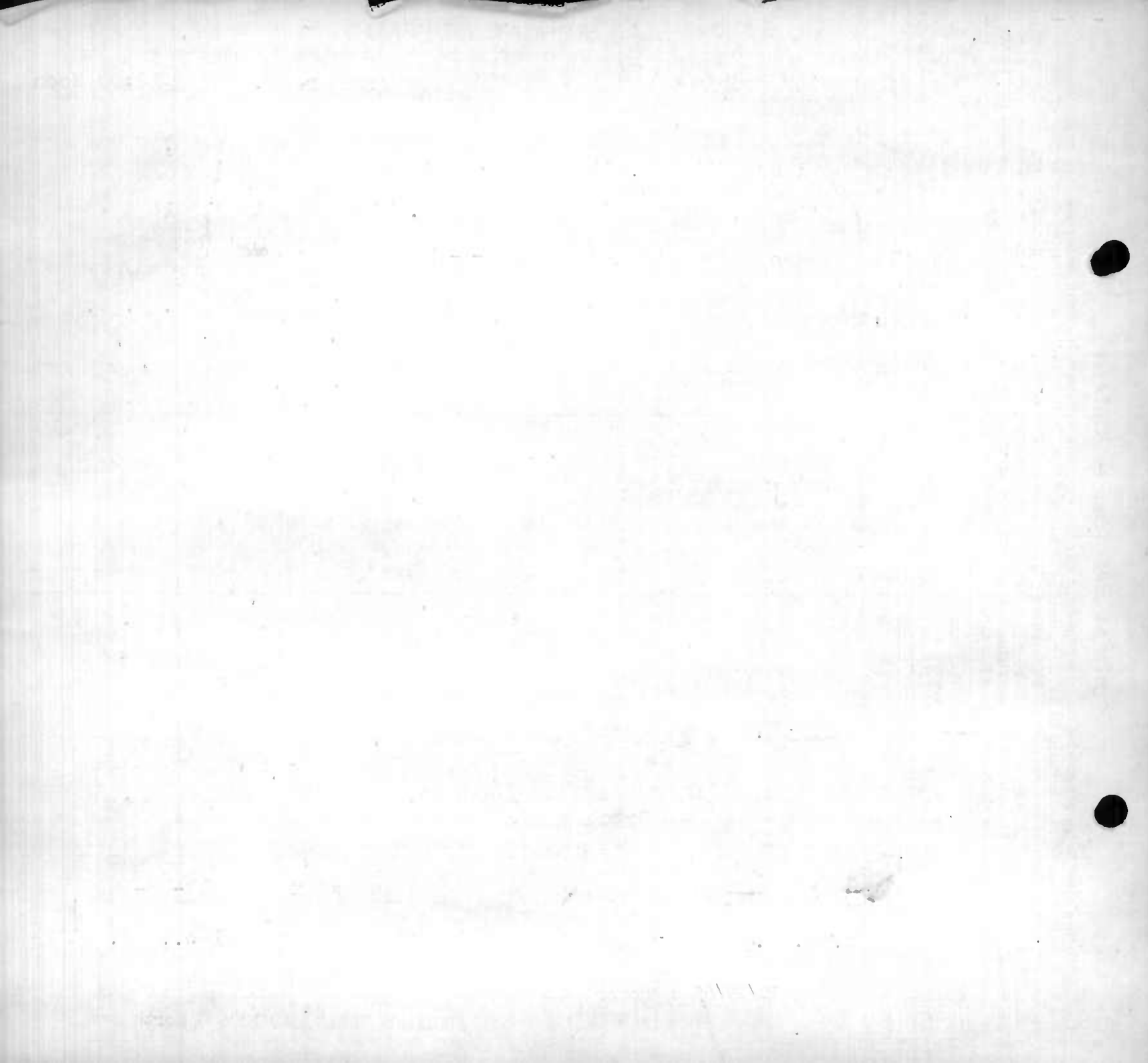
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11081				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11081	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Charity Badham</b>			
2. DATE AND HOUR OF DEATH <b>October 25, 1965 12:00 Noon</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>4-02</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>221 N. Pine Street 21201</b>		5. SEX <b>Female</b>	
6. RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>1-5-01</b>		9. AGE (In years last birthday) <b>64</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>SILAS NORMAN</b>				14. MOTHER'S MAIDEN NAME <b>CHARITY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>465 X + 151 X</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Gastric Carcinoma</b>				CAUSE OF DEATH (A) <b>Pulmonary Emboli</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 29, 1965</b> to <b>October 25, 1965</b> , that (I) (we) last saw the deceased alive on <b>October 25, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>D. E. Gaasterland</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-25-1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. D. E. Gaasterland</b>				23D. ADDRESS <b>4940 Eastern Avenue Balto., Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/29/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Roper</b>		24D. LOCATION (City, town, or county) (State) <b>NORTH CAROLINA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>ADOLPHUS HALSTEAD 1206 W North Ave</b>			



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
65 11082		65 11082					
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
ALVIN BROWN				10/26/65 8:55 a.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Provident Hospital				Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				1903 Regester St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
male	colored			30			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Fatty liver			
				(B) DUE TO			
				(C) DUE TO			
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Hypertensive cardiovascular disease			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				yes		yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		10/26/65	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
		10-30-65		Mt. Olivet		Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
OCT 29 1965		Robert E. Fisher, M.D.		A. Halstead			

VALLEY FOLIO

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 11083</b>		<b>CERTIFICATE OF DEATH</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11083</b>	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Domenick Demasi</b>				10/26/65 4:20 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Midtown Home 808 S. Payl St. Balt, Md.</b>				A. STATE <b>MD</b> B. COUNTY <b>Balt, City</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 3-02</b>			
				D. STREET ADDRESS (If rural, give location) <b>232 S. HIGH ST.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>separated</b>	B. DATE OF BIRTH <b>7/24/79</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213228440 A</b>		17. INFORMANT ADDRESS			
1B. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) <b>Cardio-Respiratory Failure</b> DUE TO		<b>CHD</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Congestive Heart Failure</b> DUE TO			
				(C) <b>CVA (old) - hemiplegia right</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 25 1962</b> to <b>Oct 26 1965</b> , that (I) (we) last saw the deceased alive on <b>Oct 26 1965</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>did</b> (did not) view the body after death.							
23A. SIGNATURE <b>Willard Appleford</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/27/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Willard Appleford</b>				23D. ADDRESS <b>5501 Park Heights Dr. Balto Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-29-65</b>		24C. NAME of CEMETERY or CREMATORY <b>New Catholic</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Frank Della Voce</b>		ADDRESS <b>322 S. High St</b>	

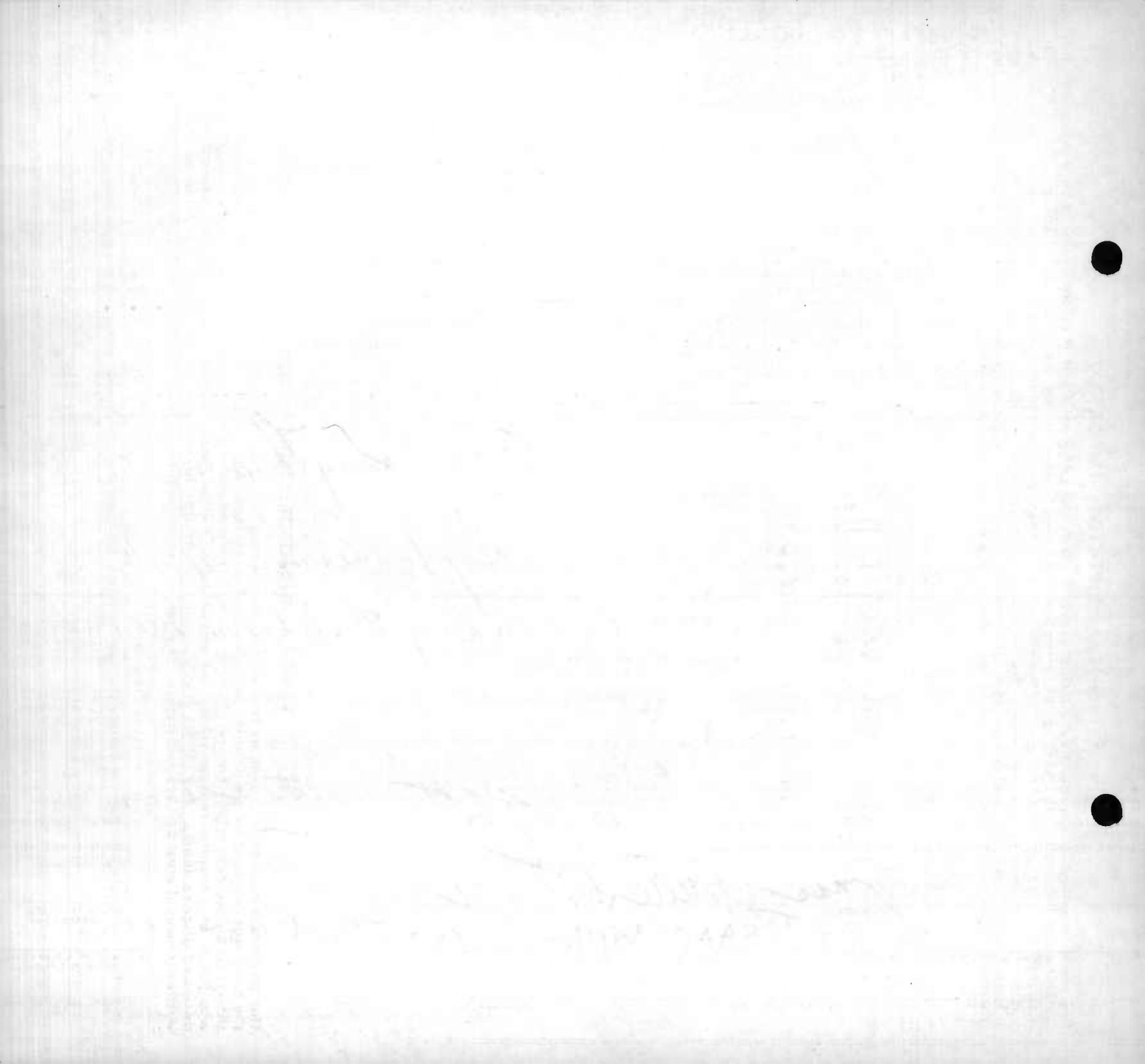




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

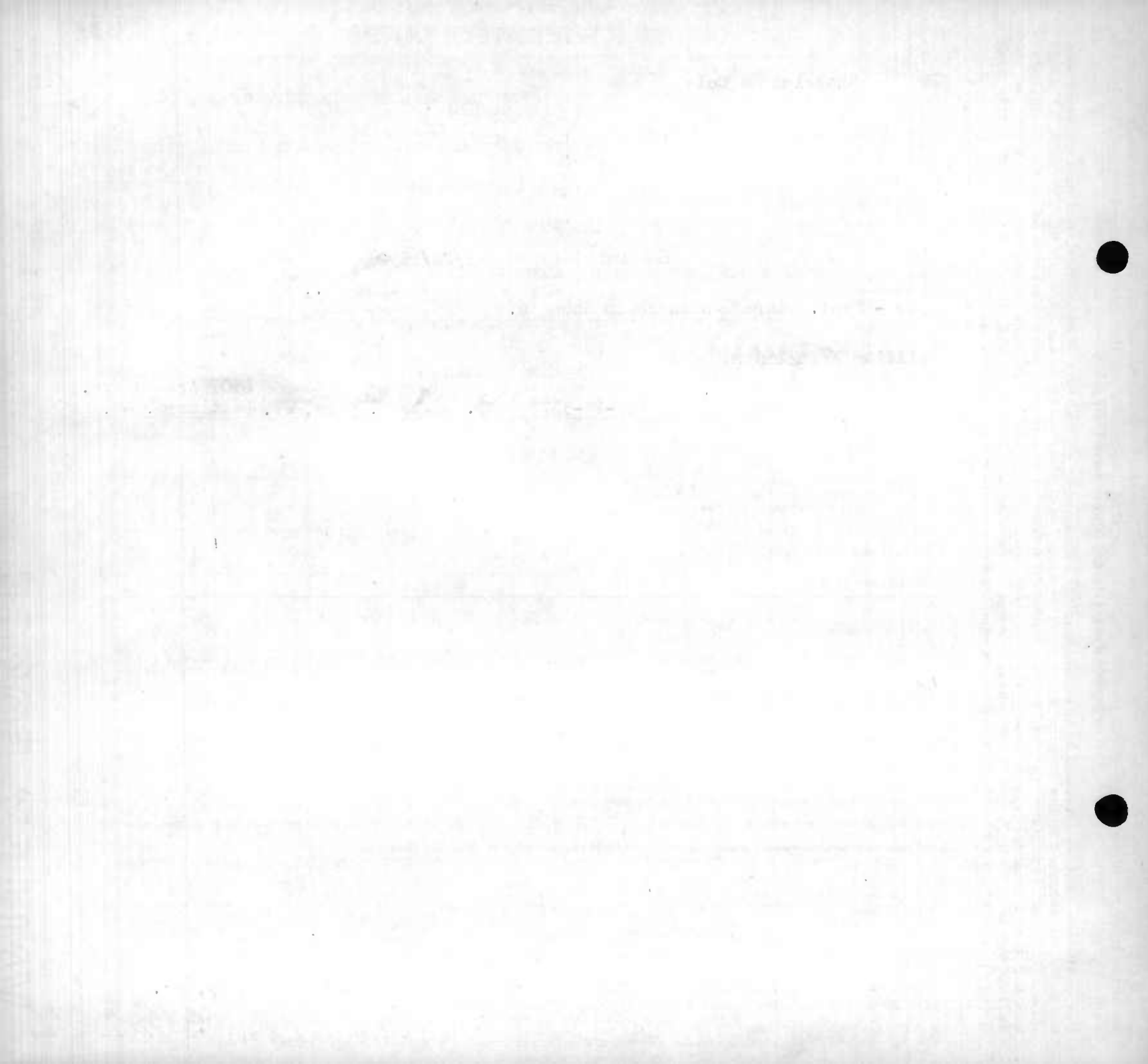
BIRTH NO. 65 11084		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11084	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Ludwik (Ludwig) Biedrzycki</b>			2. DATE AND HOUR OF DEATH <b>October 25, 1965</b>   <b>1:45 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>43 South Baltimore General Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>24-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1311 Richardson St.</b>		
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11/30/1895</b>	9. AGE (In years lost birthday) <b>69</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10B. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frank Biedrzycki</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>215-01-9553</b>	17. INFORMANT <b>Lillian Biedrzycki</b> ADDRESS <b>1311 Richardson St.</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Coronary Thrombosis</b>			CAUSE OF DEATH (A) DUE TO <b>Coronary Thrombosis one week</b> (B) DUE TO <b>Arteriosclerosis 1 year</b> (C) DUE TO <b>Hypertension about 1 year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year approx</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 1965</b> to <b>October 25 1965</b> , that (I) (we) last saw the deceased alive on <b>10/25/65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Isaac Miller</b>				23B. DATE SIGNED <b>10/27/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Isaac Miller</b>				23D. ADDRESS <b>1225 So Charles + Balt 30</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/29/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Anne Arundel, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Charles L. Stevens Funeral Home, Inc.</b>			
25D. ADDRESS <b>1501 E. Fort Avenue</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11085				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11085	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Rheuelma Cole</b>				2. DATE AND HOUR OF DEATH <b>Oct 27, 1965 18:10 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-15</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 Maryland Gen. Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>2211 W. Rogers Avenue 9</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>3/26/1892</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fitter - Dept. Store</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hochschild Kohn Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Franklin DeFord</b>				14. MOTHER'S MAIDEN NAME <b>Emily Bartlett</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-28-3377</b>		17. INFORMANT <b>Mr. Lewis T. Cole, Jr. Baltimore, Md. 25</b>		ADDRESS <b>4907 Kramme Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>331X I Cerebro Vascular Accident</b>				CAUSE OF DEATH (A) DUE TO <b>Accident</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/15/65</b> 19 to <b>10/27</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10/27</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Denton M. Sabouray M.D.</b>				23B. DATE SIGNED <b>10-27-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Denton M. Sabouray M.D.</b>				23D. ADDRESS <b>Maryland Gen. Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/30/1965</b>	24C. NAME OF CEMETERY or CREMATORY <b>Denton Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Caroline County, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Denton M. Sabouray</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Johnson &amp; Sons</b>		ADDRESS <b>Baltimore north &amp; a. ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11086		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11086	
1. NAME OF DECEASED (Type or Print) <b>LESTER B. Forrer</b>				2. DATE AND HOUR OF DEATH <b>10-28-65 1:35 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University of Md. Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL, give township) <b>Edmondson Heights 5300</b> D. STREET ADDRESS (If rural, give location) <b>1248 Newfield Rd.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>11-17-93</b>	9. AGE (In years) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner Walk, in Food Service</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Food Service</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank B. Forrer</b>				MOTHER'S MAIDEN NAME <b>Callie Humphreys</b>			
15. War (Yes, No) <b>No</b>		U. S. Armed Forces? (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>216-05-4446</b>		17. INFORMANT <b>Mrs. Genevieve Forrer 1248 Newfield Rd. Edmondson Hgts. 7</b>	
18. <b>15-7X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>G-I bleeding</b>				CAUSE OF DEATH (A) <b>G-I bleeding</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Erosion into blood vessels</b>				(B) <b>Erosion into blood vessels</b> DUE TO		<b>14 days</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Carcinoma of pancreas</b>				(C) <b>Carcinoma of pancreas</b>		<b>12 months</b>	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>11-1-64</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdominal pain</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-15</b> 19 <b>65</b> to <b>10-28</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10-28</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>B. Ann Ward</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-28-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>B. Ann Ward</b>				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/1/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Tichner &amp; Sons</b>			

10-22-61 11:52 AM

Mad. 10-17-61

UNIVERSITY OF MAD HOSP

1548 Newfield Rd

11-17-61

M. C. C.

U.S.A.

George  
Colin Humphrey

Frank

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Brown and blue  
Cannon of Cannon 14

11-19-61 11:52 AM

10-22-61 11:52 AM

10-15-61 10-18-61

10-22-61

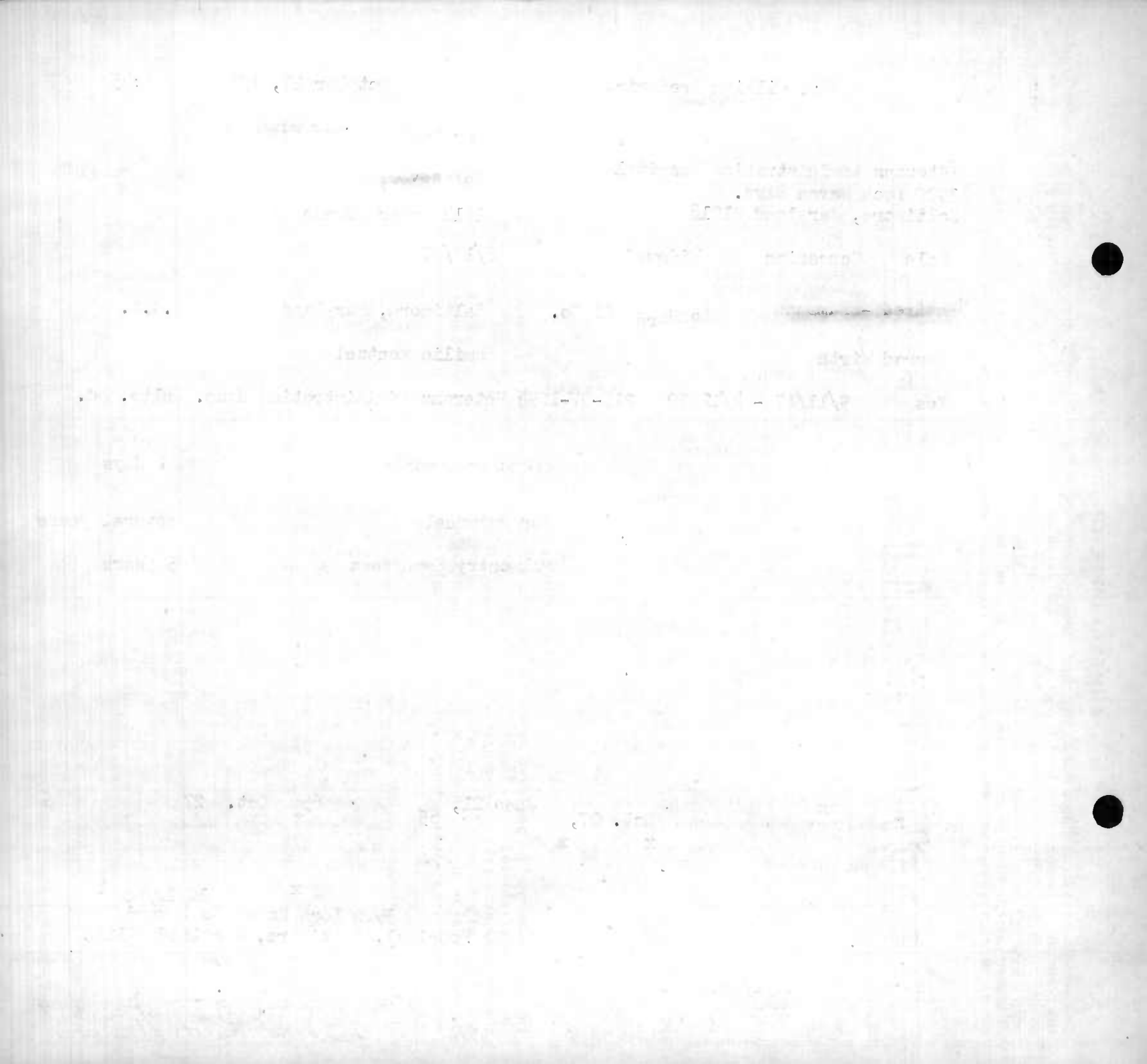


# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <span style="float: right;">65 11087</span>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">65 11087</span>	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				WIRTH, William Frederick		October 27, 1965 8:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Veterans Administration Hospital				Maryland Anne Arundel Balto.			
3900 Loch Raven Blvd.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Baltimore, Maryland 21218				Catonsville Manor			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Male		Caucasian		Widowed			
8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
8/17/97		68		Retired - Pumpman		Standard Oil Co.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Baltimore, Maryland		U.S.A.		Conrad Wirth		Emilie Mentzel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		9/11/17 - 4/12/19		215-07-1094		Veterans Administration Hosp. Balto. Md.	
18. 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		2 days	
ANTECEDENT CAUSES				(B) DUE TO		several years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO		5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 21, 19 65 to Oct. 27, 19 65, that (we) last saw the deceased alive on Oct. 27, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED			
JOHN S. HOWE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		10/28/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
JOHN S. HOWE		3900 Loch Raven Boulevard M.D. VA Hospital, Baltimore, Maryland 21218		Burial		11/1/1965	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Loudon Park Cemetery		Baltimore, Md.		OCT 29 1965		Robert E. Farley	
25C. FUNERAL DIRECTOR		ADDRESS		25D. DATE REC'D BY HEALTH DEPT.		25E. NAME OF REGISTRAR	
Wm. L. Johnson		Baltimore, Md. 21217		OCT 29 1965		Robert E. Farley	





FUNERAL DIRECTOR: IMPORTANT

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65 11088 BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Myrtle I. Cavey</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b> Registered No. <b>65 11088</b>	
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>		2. DATE AND HOUR OF DEATH <b>10-26-65 1:00 P.M.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>13 South Baltimore General Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>24-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #21230</b> D. STREET ADDRESS (If rural, give location) <b>105 E. Clement St.</b>	
5. SEX <b>F.</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>6-10-98</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Luther Beckert</b>		14. MOTHER'S MAIDEN NAME <b>RATHERINIS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. 	
17. INFORMANT <b>Family - Jane</b>		ADDRESS 	
18. <b>581.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Launer's Cirrhosis.</b>		CAUSE OF DEATH (A) <b>Launer's Cirrhosis.</b> DUE TO (B) _____ DUE TO (C) _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>10-1</b> 19 <b>65</b> to <b>10-26</b> 19 <b>65</b> , that <del>we</del> (we) last saw the deceased alive on <b>10-26</b> 19 <b>65</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Hugh J. Hargrave</b> M.D.		23B. DATE SIGNED <b>10-26-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Hugh J. Hargrave, M. D.</b>		23D. ADDRESS <b>South Baltimore General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>B</b>		24B. DATE <b>10/30/66</b>	
24C. NAME OF CEMETERY or CREMATORY <b>London Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balto</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Hargrave</b>	
25C. FUNERAL DIRECTOR <b>McCurry</b>		ADDRESS <b>-130 E Ford St.</b>	

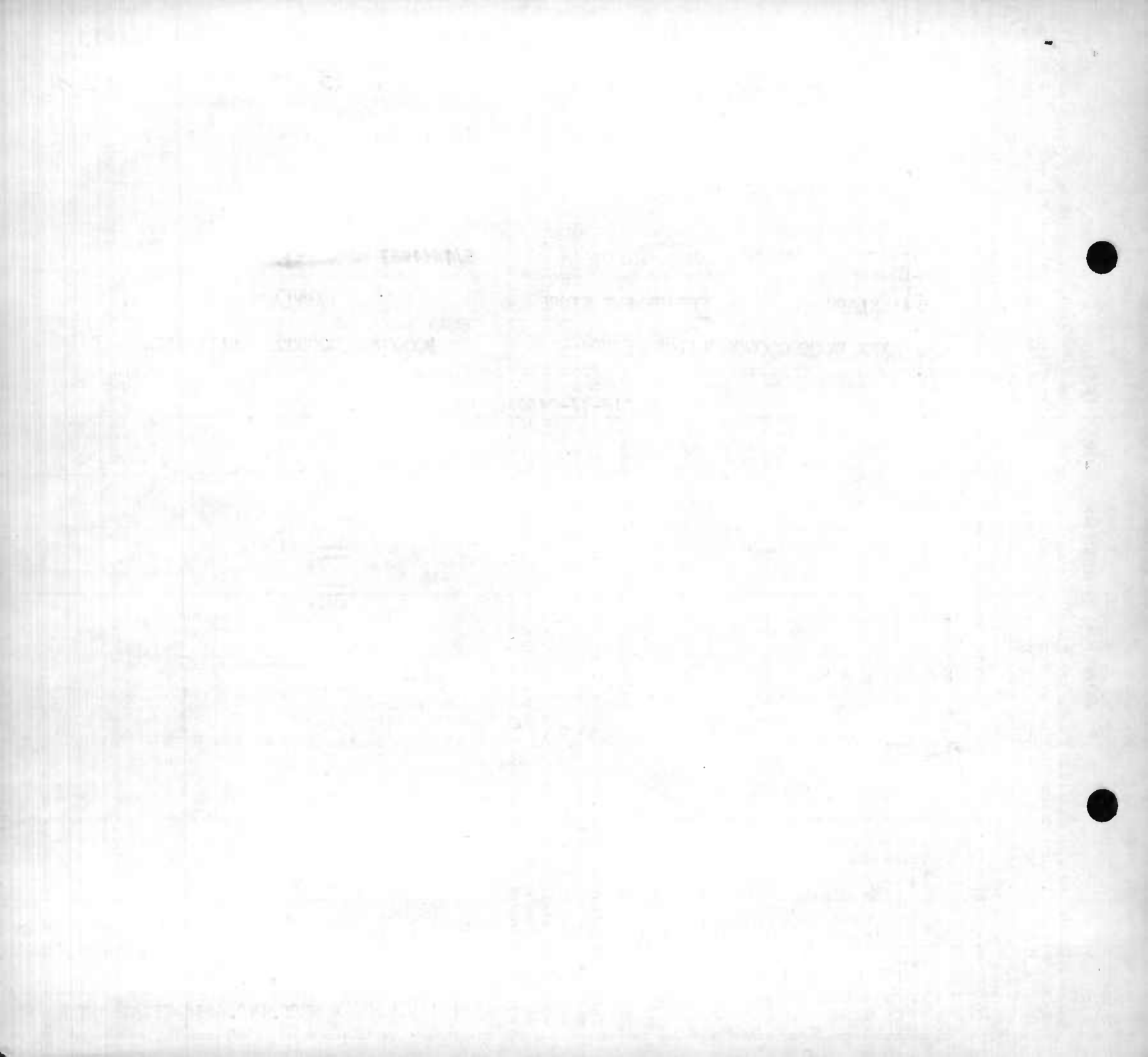
Mr. Benjamin Franklin  
White, Master  
Horsewife, Baltimore, Md.

10-12  
10-12  
7

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

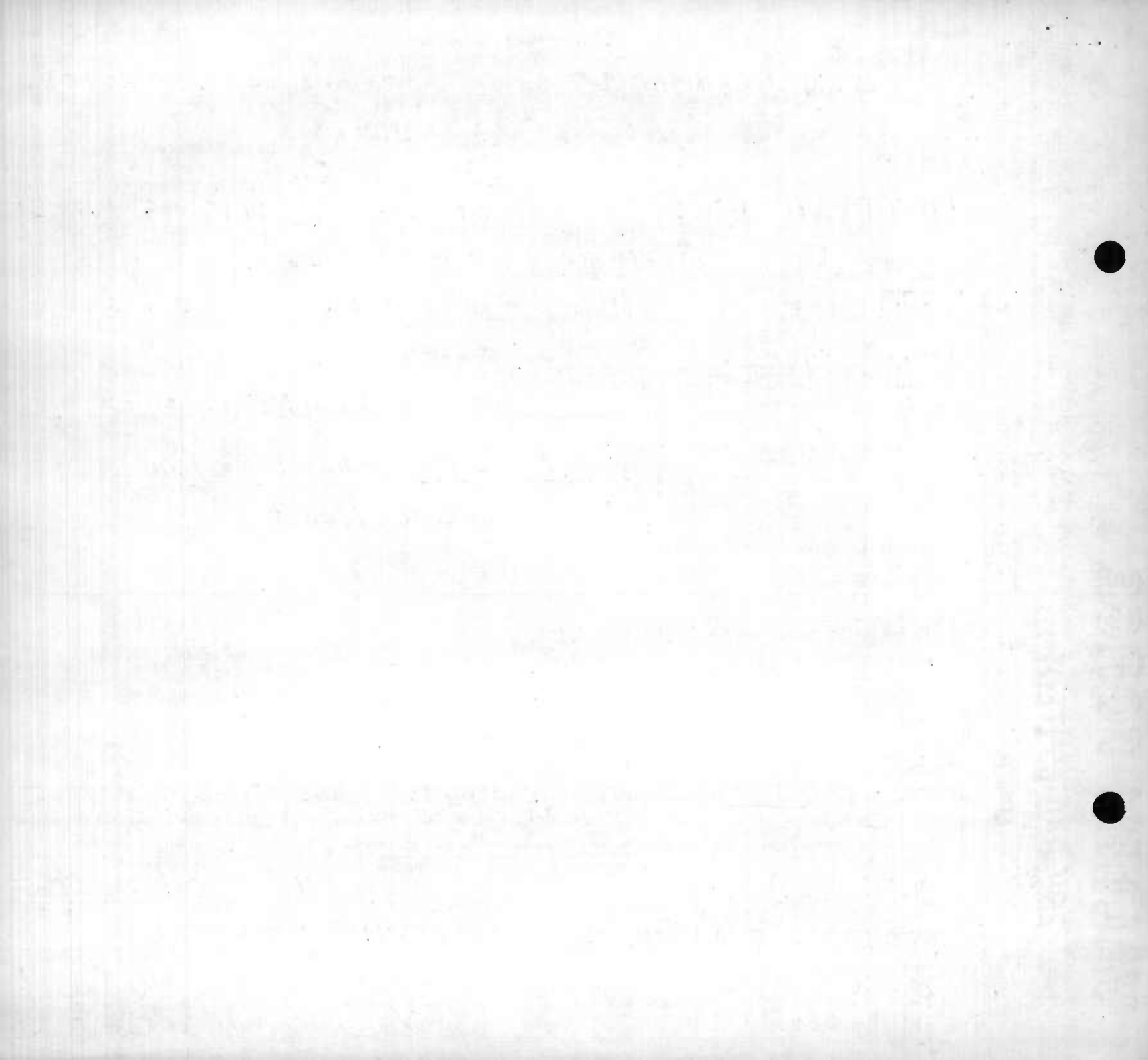
BALTIMORE CITY DEPARTMENT OF HEALTH				BIRTH NO. 65 11089		CERTIFICATE OF DEATH		Registered No. 65 11089	
1. NAME OF DECEASED (Type or Print) <b>Herman, Irene</b>				2. DATE AND HOUR OF DEATH <b>10-25-65 12:15 P. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence, before admission) A. STATE <b>Maryland</b> 8. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Maryland</b> D. STREET ADDRESS (If rural, give location) <b>3903 Edgewood Rd.</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never married</b>		8. DATE OF BIRTH <b>5/14/1907</b>		9. AGE (In years last birthday) <b>58</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DEPARTMENT STORE</b>		11. BIRTHPLACE (State or foreign country) <b>Balto, MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>XXXXXXXXXXXXX JULIUS HERMON</b>				14. MOTHER'S MAIDEN NAME <b>XXXXXXXXXXXXX ELIZABETH ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-0480</b>		17. INFORMANT <b>Harry M. Walen</b>			ADDRESS <b>5356 Carriage Ct.</b>		
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Cerebral Vascular accident</b> DUE TO (B) <b>Hypertension</b> DUE TO (C) <b>Diopathic</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>		21C. WHERE DID INJURY OCCUR? <b>none</b>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <b>none</b>		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>none</b>					
22. I certify that (1) (this hospital) attended the deceased from <b>10/17/65</b> to <b>10-25</b> 19 <b>65</b> , that (1) (we) last saw the deceased alive on <b>10-25</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Harry M. Walen</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-25-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Harry M. Walen</b>				23D. ADDRESS <b>5356 Carriage Ct. Baltimore, Maryland</b>					
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/26/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>SHAAREI ZION</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fader</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>					
				ADDRESS <b>6010 REISTERSTOWN RD</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11030		CERTIFICATE OF DEATH		Registered No. 65 11030	
1. NAME OF DECEASED (Type or Print) <b>JEAN BERNHARDT</b>				2. DATE AND HOUR OF DEATH <b>October 24, 1965 4:45 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
D. STREET ADDRESS (If rural, give location) <b>4411 LIBERTY HEIGHTS AVENUE</b>				5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED <b>MARRIED</b>	
8. DATE OF BIRTH <b>10-18-13</b>				9. AGE (In years last birthday) <b>52</b>		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS DICKOV</b>				14. MOTHER'S MAIDEN NAME <b>HENRI BESSIE Kudemman</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>HENRY BERNHARDT - same as above</b>			
18. <b>420.11</b>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) <b>Acute Myocardial Infarction</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Rheumatic Heart</b>					
				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>NONE</b>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>October 12, 1965</b> to <b>October 24, 1965</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>October 24, 1965</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> (did not) view the body after death.									
23A. SIGNATURE <b>D. T. Mahusay</b>				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Oct. 24, 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>DESIDERIA T. MAHUSAY</b>				23D. ADDRESS <b>M.D. LUTHERAN HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/26/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Chesik Ameno (Arlington)</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jarboe, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>St. Lawrence Dev. Inc. 6010 Kiltiernan Rd.</b>					

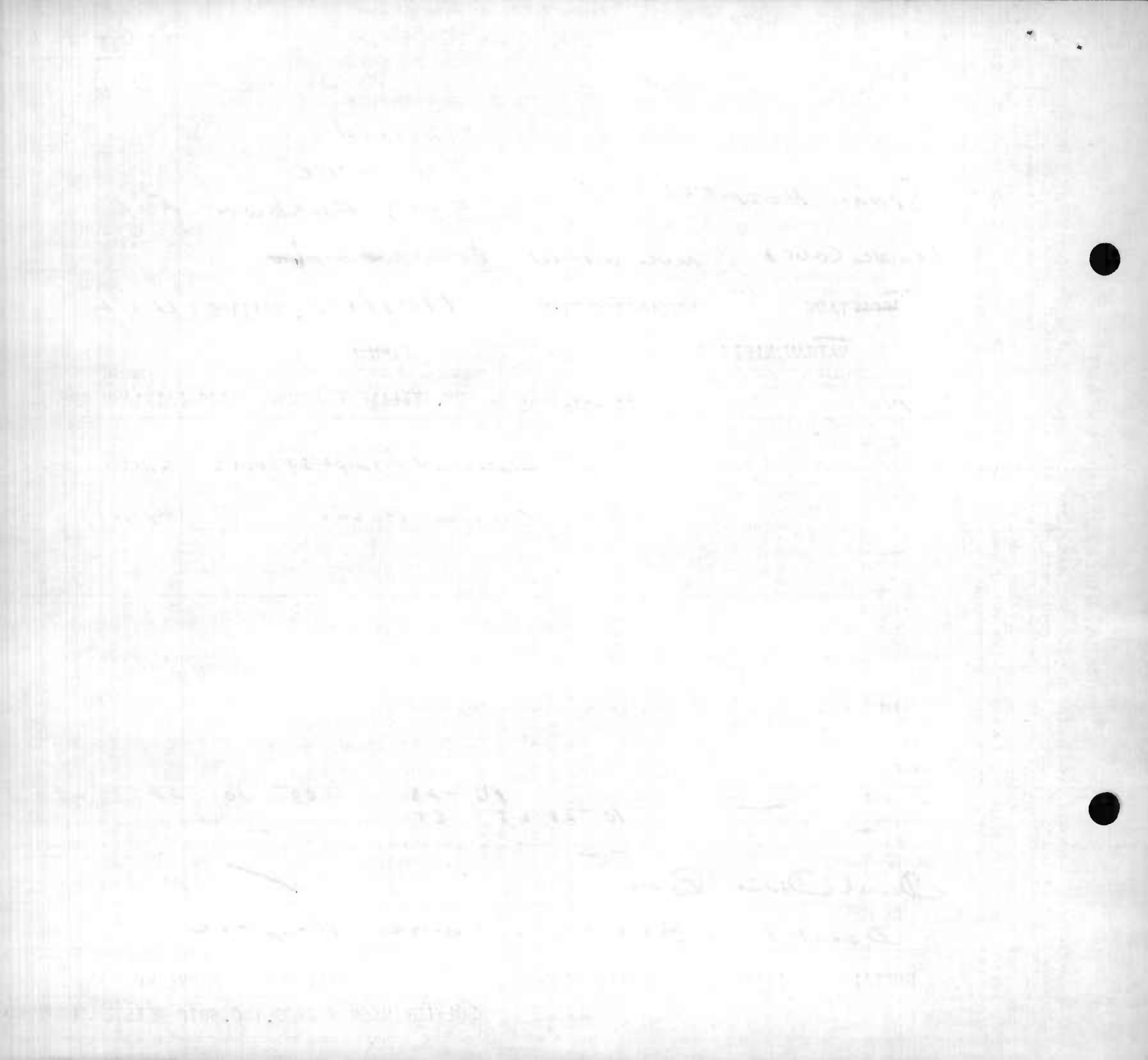




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <span style="font-size: 1.5em;">65 11091</span>		<b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">65 11091</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">KLEIN, ROSE H.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10-28-65 12:25 a.m.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">28-31</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">42 Sinai Hospital</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3309 FAIRLAWN AVE.</span>			
5. SEX <span style="font-size: 1.2em;">female</span>	6. RACE <span style="font-size: 1.2em;">Caucas.</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Never married</span>	8. DATE OF BIRTH	9. AGE (In years last birthday) <span style="font-size: 1.2em;">64</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">SECRETARY</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">ACCOUNTING FIRM</span>		BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland, BALTIMORE U.S.A.</span>	
11. FATHER'S NAME <span style="font-size: 1.2em;">NATHAN KLEIN</span>		12. CITIZEN OF WHAT COUNTRY?		13. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MINNIE ?</span>	
14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		15. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-01-0205</span>		16. INFORMANT <span style="font-size: 1.2em;">MRS. TELLIE FOOKSMAN</span> ADDRESS <span style="font-size: 1.2em;">5309 FAIRLAWN AVE</span>	
17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Generalized Lymphosarcoma</span>		18. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Approx. 4 yrs.</span>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">CARCINOMATOUS</span>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <span style="font-size: 1.2em;">200.1 I</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10-23</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">10-28</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10-28-65</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Daniel David Bass</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">10-28-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Daniel David Bass</span>		23D. ADDRESS <span style="font-size: 1.2em;">Sinai Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">10/29/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">SHAAREI TFILOH</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE MARYLAND</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 29 1965</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE HEALTH DEPARTMENT				Registered No. 65 11092			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
WILKERSON, Earl Douglas				October 27, 1965				5:50 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY							
Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				Maryland Anne Arundel							
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
				Annapolis							
				D. STREET ADDRESS (If rural, give location)							
				13 Boxwood Road							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
Male	Caucasian	Married	8/6/37	28							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Road Work Construction			Construction		Anne Arundel, Co., Md.		U.S.A.				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Melvin Wilkerson Sr.				Marion Rye							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes 9/1/55 - 8/31/59			213-34-0893		Veterans Administration Hosp. Balto. Md.						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) Congestive Heart Failure				1 week			
ANTECEDENT CAUSES				(B) Hodgkins Disease				5 years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)							
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
O											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>									
22. I certify that (X) (this hospital) attended the deceased from Dec. 29, 19 64 to Oct. 27, 19 65, that (X) (we) last saw the deceased alive on Oct. 27, 19 65 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
John S. Howe				10/28/65							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
JOHN S. HOWE				3900 Loch Raven Boulevard VAH Baltimore, Maryland 21218							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		10-31-65		Hillcrest Memorial		Annapolis Md					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
OCT 29 1965		Robert E. Taylor		John M. Taylor Sons		Annapolis Md					

1

[illegible][illegible]

20-10-2

[illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 11093		M.E. CASE NO.		65 11093	
1. NAME OF DECEASED (Type or Print) <b>SIMS, William NMI</b>			2. DATE AND HOUR OF DEATH <b>October 28, 1965 10:25 a M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-33</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2350 Hollins Ferry Road</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5/30/96</b>	9. AGE (In years lost birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Color Mixer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Md. Glass Corp.</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Nick Simms</b>			14. MOTHER'S MAIDEN NAME <b>Hattie Williams</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 8/22/18 - 8/5/19</b>		16. SOCIAL SECURITY NO. <b>213 09 7201</b>	17. INFORMANT ADDRESS <b>VA Hospital Records 3900 Loch Raven Blvd., Baltimore, Md 21218</b>		
18. <b>523.01 x 150X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Acute pulmonary edema with bilateral pleural effusions</b> (B) <b>Congestive heart failure</b> (C) <b>Silicosis</b>  II Esophagogastrectomy for carcinoma of esophagus		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 27th 19 65</b> to <b>October 28th 19 65</b> , that (I) (we) last saw the deceased alive on <b>October 28th 19 65</b> and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anna R. Berky</b>			23B. DATE SIGNED <b>10/28/65</b>		23C. PHYSICIAN'S NAME (Type) <b>Anna R. Berky</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>11-1-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		
25B. NAME OF REGISTRAR <b>Robert E. Faldema</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		25D. ADDRESS <b>661 W. Barre St.</b>	

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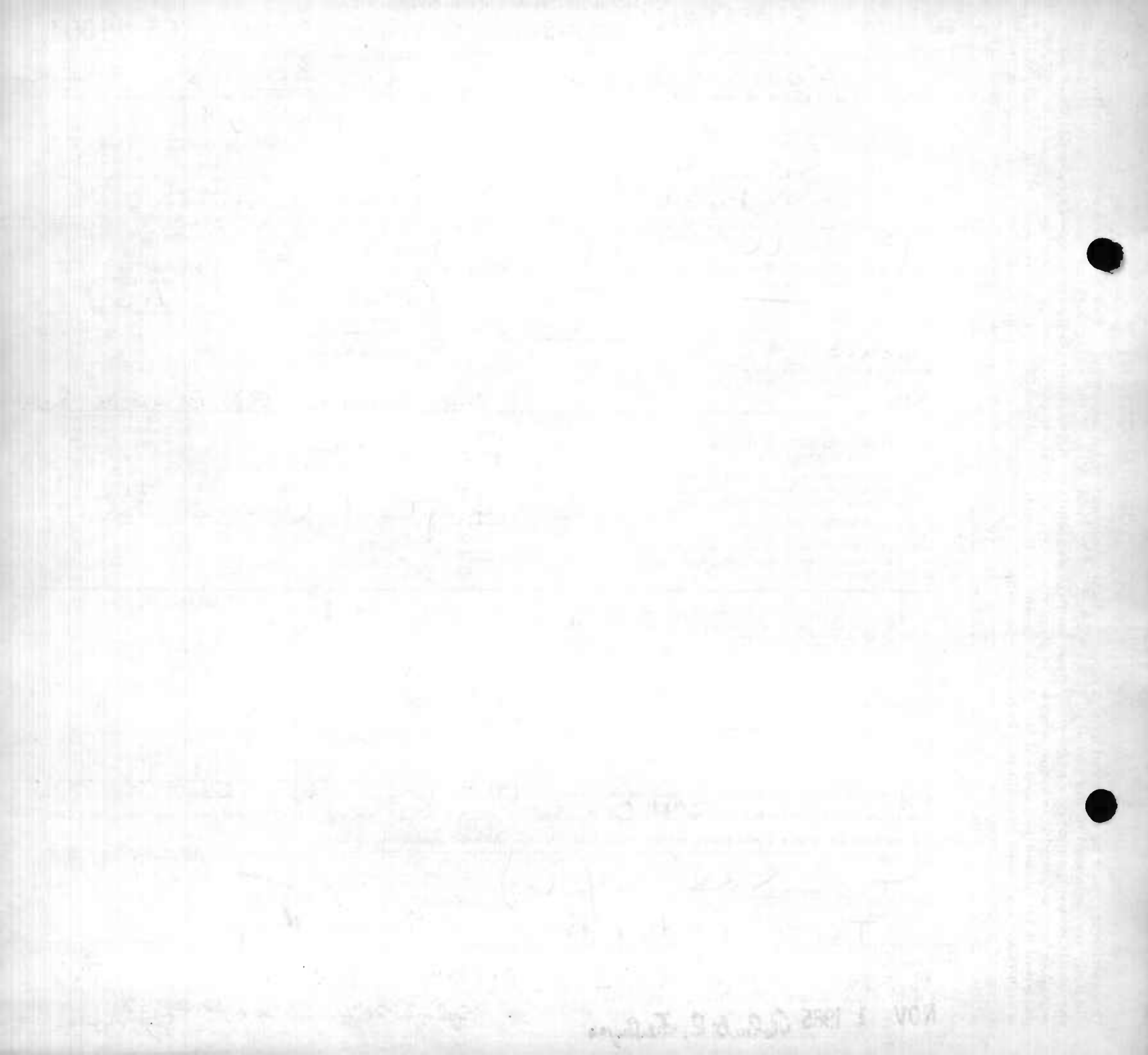


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11094		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11094	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FREDA COOPER</b>		2. DATE AND HOUR OF DEATH <b>OCT 30 1965 3:45 AM.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>15-12</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hosp Balto</b>		D. STREET ADDRESS (If rural, give location) <b>3745 Reisterstown Rd</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>3/24/97</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Louis</b>		14. MOTHER'S MAIDEN NAME <b>RACHAEL</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MAX COOPER</b>		ADDRESS <b>6971 BLANCHE ROAD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>3-76X1</b>		CAUSE OF DEATH (A) DUE TO <b>Peritonitis</b> (B) DUE TO <b>Ruptured Viscus</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>Unknown Duration</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCEND C CHF</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 1 1965</b> to <b>OCT 30 1965</b> , that (I) (we) last saw the deceased alive on <b>30th OCT 30 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Terrence M. Himebaugh</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/30/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>TERRENCE M. HIMEBAUGH</b>		23D. ADDRESS <b>Sinai Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10/31/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, Inc.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11095				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11095	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HELEN BERNSCHEIN				10-27-65 4:37 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				3611 6th St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
Female	White	WIDOWED	2-25-02	63			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife			Maryland		U.S.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
WILLIAM BALLENTINE			ELIZABETH DUNN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					Miss Beatrice E. Bernschein, 3611 Sixth St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		(B) DUE TO	
ANTECEDENT CAUSES				Brain tumor		7/1-1965	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. OPERATION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
10-26-65		Right parietal tumor		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10-24 19 65 to 10-27 19 65, that (I) (we) last saw the deceased alive on 10-27 19 65 and that (my) (our) opinion death occurred on the date at 4:37 p.m. and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Sumio Uematsu						10-27-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-29-1965		Holy Cross Cemetery		Ritchie Hwy., A.A.Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Nov 1 1965		Robert E. Farber, M.D.		George J. Gonce, 4001 Ritchie Hwy. (25)			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11096		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11096	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John Mc Nain		2. DATE AND HOUR OF DEATH 10/28/65 11 20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A, STATE Maryland B, COUNTY 8-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp - Balto. 12-7-65		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 1827 N. Gay St		212 13			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/27/11	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Barney Mc Nain			
14. MOTHER'S MAIDEN NAME Nancy Mc Neal		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown			
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Ester Mc Nain (Wife)			
18. ADDRESS 1827 N. Gay St.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction Aged			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HSCVD Essential Hypertension		21. INTERVAL BETWEEN ONSET AND DEATH 15 yrs 15 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/7 1965 to 10/28 1965, that (I) (we) lost saw the deceased alive on 10/28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chester C Collins Jr M.D.		23B. DATE SIGNED 10/29/65		23C. PHYSICIAN'S NAME (Type) Chester C Collins Jr M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-3-65		24C. NAME OF CEMETERY or CREMATORY Arbutus Cem.	
24D. LOCATION Arbutus		24E. DATE REC'D BY HEALTH DEPT. NOV 1 1965		24F. NAME OF REGISTRAR Robert E. Fink	
24G. FUNERAL DIRECTOR E. S. Wilson		24H. ADDRESS 1000 Brady Ave		24I. DATE 11-3-65	

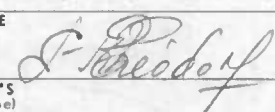
11-1-65

Called Hospital for Sept &amp; Rec

NOA 142 000 0.5 1000

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11097</b>	
BIRTH NO. <b>65 11097</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Freddie W. Jordan</b>		2. DATE AND HOUR OF DEATH <b>October 28, 1965</b> <b>11:45a M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland 21217</b>		A. STATE <b>Maryland</b> B. COUNTY <b>13-04</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>2305 Ruskin Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>Nov. 29, 1919</b>	9. AGE (In years last birthday) <b>45</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>John W. Jordan - brother</b> Phone: <b>Di. 2-6231</b> ADDRESS <b>2737 E. Preston St.</b>		
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>MASSIVE CEREBRAL HEMORRHAGE</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 28, 1965</b> to <b>October 28, 1965</b> that (I) (we) last saw the deceased alive on <b>October 28, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>October 28, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Roger Theodore</b>		23D. ADDRESS M.D. <b>1514 Division St. - Baltimore 17, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11-2-65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Lawrenceville Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Lawrenceville VA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Daniel Brown Funeral Home Lawrenceville, VA</b>	

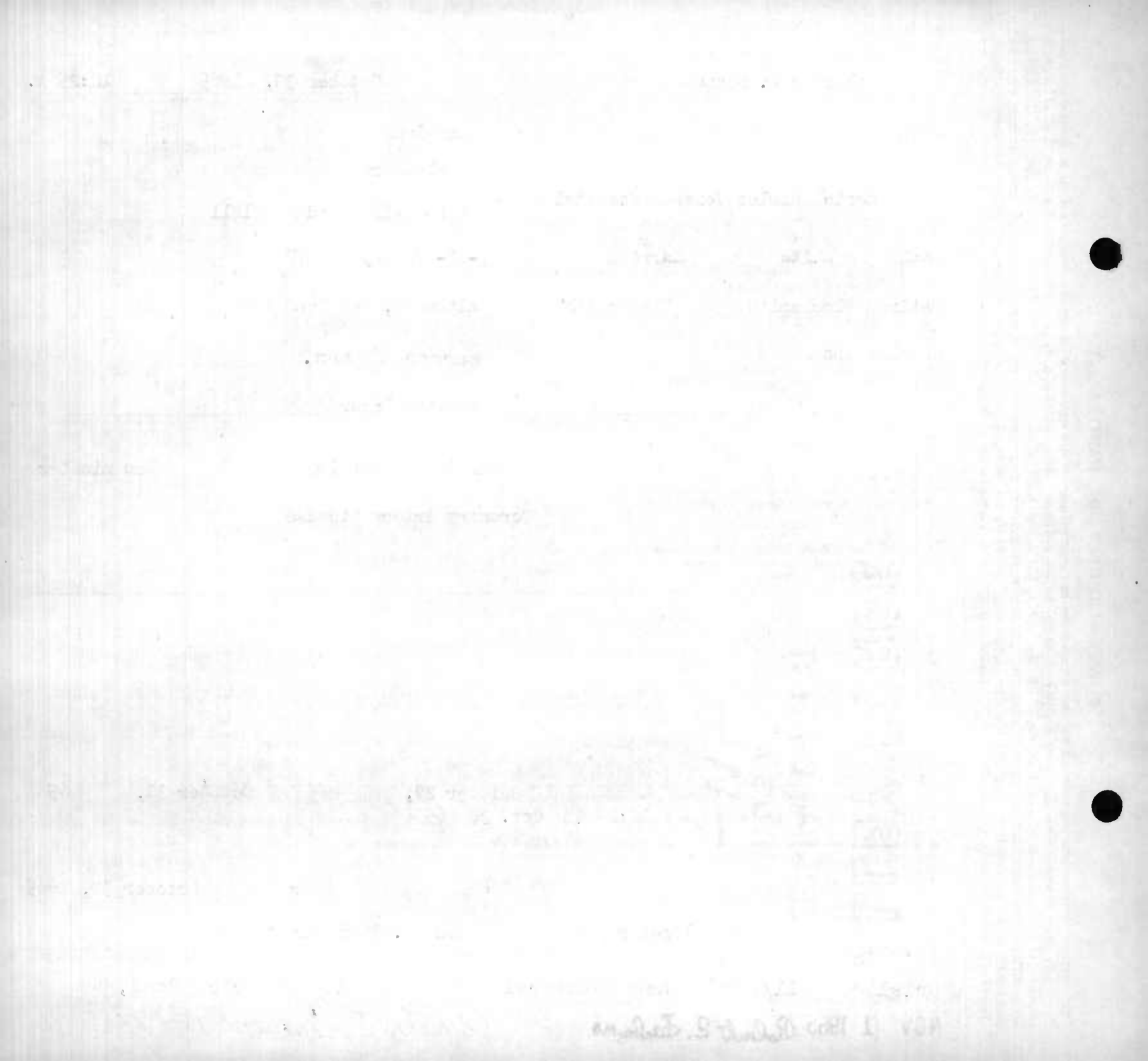




# FUNERAL DIRECTOR: IMPORTANT

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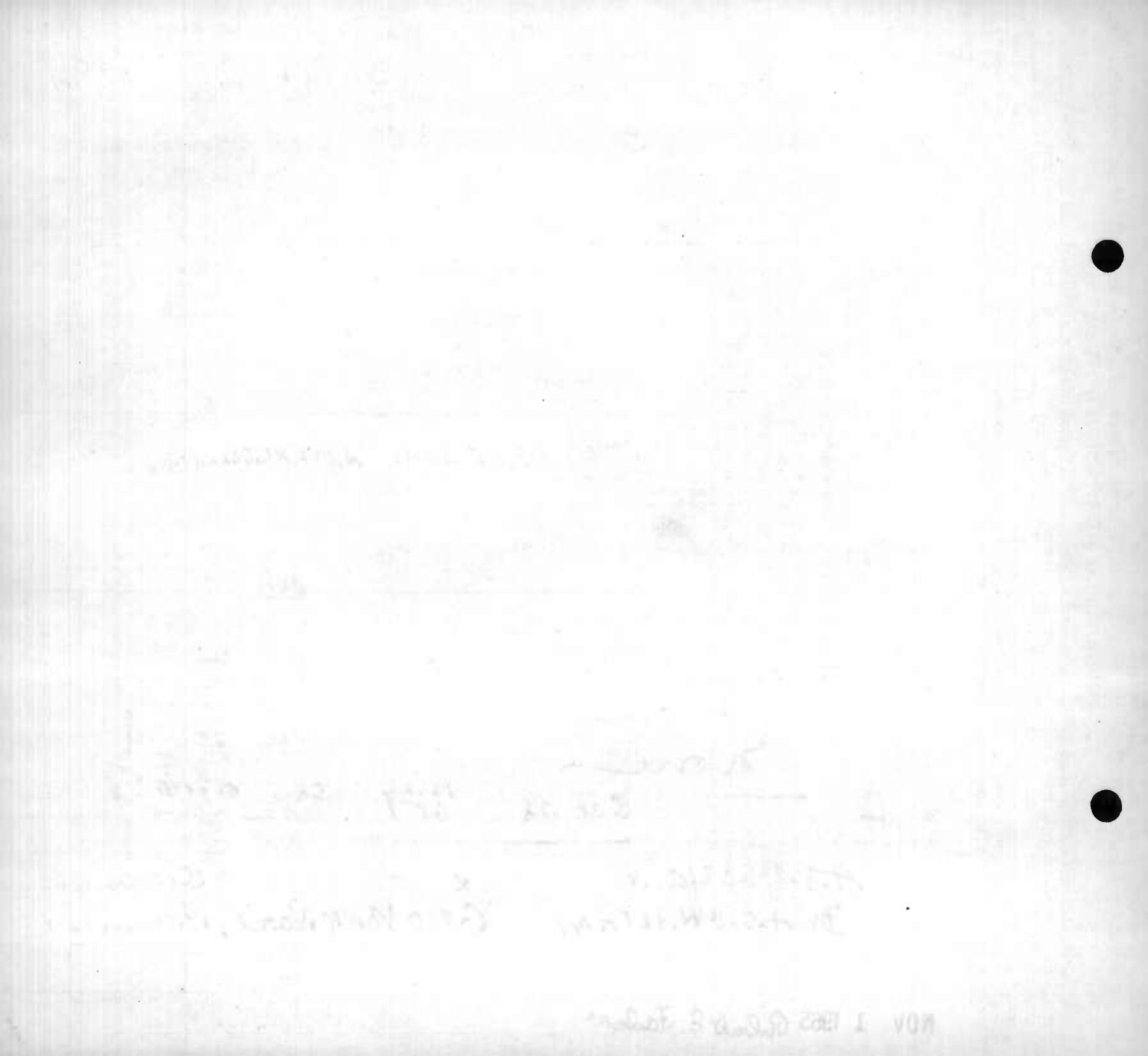
BIRTH NO. 65 11098				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11098	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Charles J. Spann</b>				2. DATE AND HOUR OF DEATH <b>October 30, 1965 10:25 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-08</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>North Charles General Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>4120 Falls Road 21211</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7-22-87</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Blacksmith</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Blacksmith</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Spann</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Marx.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Hospital Record</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>Myocardial Infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>October 29, 1965</b> to <b>October 30, 1965</b> , that (I) (we) last saw the deceased alive on <b>10:25 AM Oct. 30, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Sheldon Goldgeier</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>October 30, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sheldon Goldgeier</b> M.D.				23D. ADDRESS <b>848 W. 36th Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/2/65</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Old Frederick Road, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Quentin E. Donovan</i>		ADDRESS <i>3818 Holmwood Ave</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 2em;">65 11099</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 2em;">65 11099</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Wallace R. Busick, Sr.		Oct 28 <sup>th</sup> 1965 11:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
519 Chestnut Hill Avenue Baltimore, Md. 21218			Maryland 9-03		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			519 Chestnut Hill Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	White	Married	Feb. 8, 1884	81	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Shipping clerk				Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Daniel B. Busick			Mary Ann Perego		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		212-01-0619A	Ethel M. Busick (Wife) Same		
18. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CEREBRAL ARTERIOSCLEROSIS 7 yrs		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			7 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		None		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
None		None		None	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
None		White At Work <input checked="" type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 1958 to Oct 28 1965, that (I) <del>was</del> lost saw the deceased alive on Oct 28 1965 and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A.S. Chalfant				Oct 28 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. A.S. CHALFANT				6210 YORK ROAD, Baltimore 18, Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/1/1965		Loudon Park Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		24F. LOCATION (State)	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 1 1965		Robert E. Farber		Eugenia K. Seitz 5209 York Rd. Seitz funeral Home Baltimore, Md.	



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 11100	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 65 11100	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
MURIEL G. FLITTON			10/27/65 4:45 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
Union Memorial Hospital			Maryland		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			2731 Elkader Rd.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
female	white	Widowed	April 2, 1894	71	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Maryland		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William C. Cole			Margaret Elin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					3800 REXMERE RD. MR. CHARLES K. FLITTON
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Arteriosclerotic and hypertensive cardio-vascular disease		
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		10/28/65	
Werner U. Spitz, M.D.					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Entombment		Oct. 30, 1965		LORRAINE PARK	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
NOV 1 1965		Robert E. Farber, M.D.		G. TRUMAN SCHWAB	
				3572 Frederick Ave. (29)	

WALLING FORTICE

NOV 1 1955

NOV 1 1955



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 65 11101

BIRTH NO. 65 11101

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print) *Knight Nettie*

2. DATE AND HOUR OF DEATH

10-28-65 11<sup>30</sup> P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)34 *BON SECOURS*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *MD.* B. COUNTY *- EDGEMOND NURS. HOME*

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

*BALTO.* *27-12*

D. STREET ADDRESS (If rural, give location)

*6000 BELLEVA AVE*

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.*FEMALE WHITE SINGLE**11-12-76**88*10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?*Never Employed**Home**MD. Carroll Co.**U.S.*

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

*Upton R. Knight**ANNA A. Roach*15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*No**None**Mr Arthur Bell 507 Beaumont Avenue*

#12

18. *540.01*DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

*Internal hemorrhage due  
to upper gastro-intestinal  
bleeding. Probably  
due to Peptic ulcer.*INTERVAL BETWEEN  
ONSET AND DEATH*hours.*

(A) DUE TO

(B) DUE TO

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)21E. INJURY OCCURRED  
While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *Oct 28* 19 *65* to *Oct 28* 19 *65*,  
that (I) (we) lost saw the deceased alive on *Oct 28* 19 *65* and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

*Oct 28-65*23C. PHYSICIAN'S  
NAME (Type)

M.D.

23D. ADDRESS

*Box Secours Hospital Md.*24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

*Burial**11-1-1965**Loudon Park Cemetery**Baltimore, Co.**M*

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

*NOV 1 1965**Robert E. Fairbanks**Lazarus Funeral Home 7401 Belair Road*



Handwritten text, mostly illegible due to fading and bleed-through. Some words like "Verein" and "Kasse" are visible.

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37-13-66 1

65 11102

BALTIMORE HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 11102

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Brazil Dotson

2. DATE AND HOUR OF DEATH

10-26-1965 5:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4940 Eastern Avenue, Baltimore City Hospitals 21224

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12-1894

9. AGE (In years  
last birthday)

70

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Horace Mills

14. MOTHER'S MAIDEN NAME

Charlotte Barnes

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 422.14-260X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

## CAUSE OF DEATH

(A) DUE TO

Pulmonary Embolus

hours

(B) DUE TO

Cerebral Thrombosis-bilateral

weeks

(C) DUE TO

Arteriosclerotic Cardio

Vascular Disease

years

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-25-19 63 to 10-26-19 65

that (I) (we) last saw the deceased alive on 10-26-19 65 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Laurice McAfee

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10-26-1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Laurice McAfee

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-29-65

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park Arbutus Md.

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

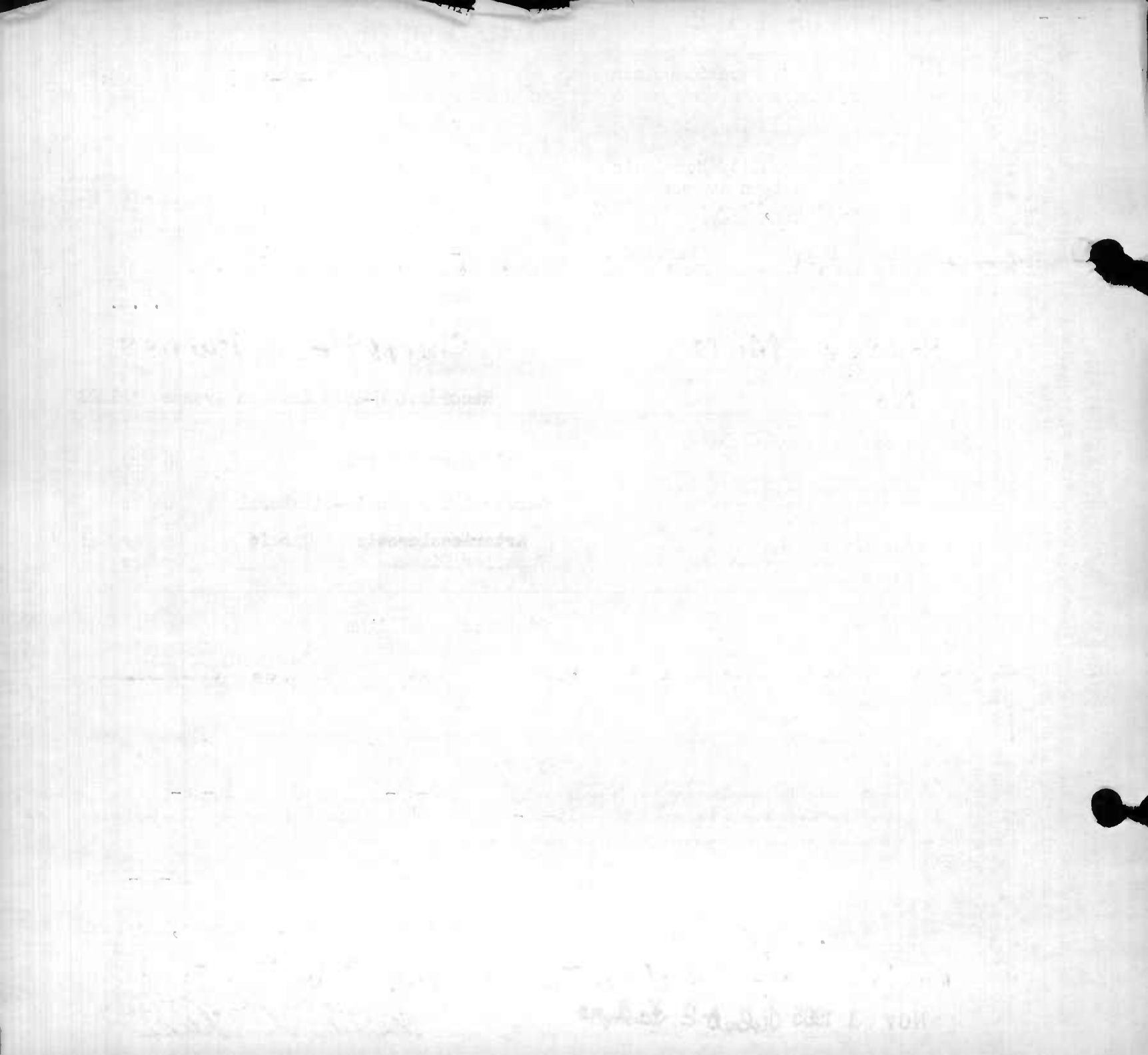
Joseph L. Russell

ADDRESS

25D. ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 65 11103											
CERTIFICATE OF DEATH											
Registered No. 65 11103											
1. NAME OF DECEASED (Type or Print) <b>HARRY E. MADDOX</b>						2. DATE AND HOUR OF DEATH <b>10-28-65</b> <b>2 P. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>						A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b>					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Lutherville, Md.</b>						D. STREET ADDRESS (If rural, give location) <b>Broadway Road 21093</b>					
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>12-10-1883</b>		9. AGE (In years last birthday) <b>81</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Maddox</b>						14. MOTHER'S MAIDEN NAME <b>Fannie Hughes</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-40-0914</b>		17. INFORMANT ADDRESS <b>Mrs John F. Tracey Broadway Road</b>					
18. <b>10-3-81</b> CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>advanced ca of colon</b>											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>old age</b>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>10-23-65</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ca of colon</b>				20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>OCT. 22</b> 19 <b>65</b> to <b>OCT. 28</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>OCT. 28</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Manuel D. Ramos</b>								M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-28-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>MANUEL D. RAMOS, M.D.</b>								23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>11-1-1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Farley</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Lansdowne Funeral Home 2701 Belair Rd 36</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 11104					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <b>MARIE E. KESSLER</b>					2. DATE AND HOUR OF DEATH <b>Oct 27, 1965 5:10 P. M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 MARYLAND GEN. HOSPITAL</b>					A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 3300</b>				
					D. STREET ADDRESS (If rural, give location) <b>209 Westowne Rd.</b>				
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>S</b>		8. DATE OF BIRTH <b>JAN. 20, 1894</b>		9. AGE (In years last birthday) <b>71</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TELLER-RET.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BANK</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>JOHN M. KESSLER</b>					14. MOTHER'S MAIDEN NAME <b>ANNA DOTTERWEICH</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO.		17. INFORMANT <b>Raymond Kessler</b> ADDRESS <b>same</b>		
18. <b>330X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH <b>Sabapashoid Hemorrhage</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO (B) DUE TO (C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>0</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> 19 <b>65</b> to <b>Oct 27</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Oct 27</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Rolando M. Sabundayo</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>10-27-65</b>				
23C. PHYSICIAN'S NAME (Type) <b>ROLANDO M. SABUNDAYO</b> M.D.					23D. ADDRESS <b>MARYLAND GEN. HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-30-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Farley-Cummings Funeral Home Catonsville, Md.</b>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 11105	
CERTIFICATE OF DEATH				Registered No. 65 11105	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Clarence Parker		10-28-65 12:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
South Baltimore General Hosp.		Maryland MD			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M.		white		married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Retired		Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Benjamin PARKER		Lydia			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		MRS. JOAN MURPHY		3380 ST. BENEDICT ST BALTO 29 MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 I		Congestive Heart Failure		10 days	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Anterosclerotic Heart Disease		6 years	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		Pulmonary Embolus		10 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 10-18-65 to 10-28-65, that (we) lost saw the deceased alive on 10-28-65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Robert T. Parker				10-28-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ROBERT T. PARKER				South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		10/30/65		ST. Johns Cem.	
24D. LOCATION		24E. LOCATION		24F. LOCATION	
Elliott City		Howard Co. Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 1 1965		Robert E. Parker, M.D.		C. S. Mac Nabb 301 Frederick Rd #28	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11106		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11106	
1. NAME OF DECEASED (Type or Print) <b>PURKINS, MARY</b>			2. DATE AND HOUR OF DEATH <b>10-29-65 6:55 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <b>MONTEBELLO STATE Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND.</b> B. COUNTY <b>16-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2804 W. BRIGHTON ST. 21216</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1-10-10</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM HAND</b>			11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>SAMUEL WINDBUSH</b>			14. MOTHER'S MAIDEN NAME <b>MOLLIE WINDBUSH</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS. BONNER</b> ADDRESS <b>1604 W. Fayette St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>422.11</b>			CAUSE OF DEATH (A) <b>LEFT Hemiplegia</b> DUE TO (B) <b>THROMBOSIS RT. MIDDLE Cerebral ARTERY</b> DUE TO (C) <b>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			INTERVAL BETWEEN ONSET AND DEATH <b>10 Mo</b> <b>① 1963</b> <b>② JAN 1965</b> <b>?</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>5-4-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GANGRENE RT. FOOT</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 18 1965</b> to <b>OCTOBER 29 1965</b> . that (I) (we) last saw the deceased alive on <b>OCTOBER 29 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas P. Connelly</b>				23B. DATE SIGNED <b>10-29-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>THOMAS P CONNELLY</b>				23D. ADDRESS M.O. <b>MONTEBELLO STATE Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/3/65</b>		24C. NAME of CEMETERY or CREMATORY <b>St. John</b>	
24D. LOCATION (City, town, or county) (State) <b>Greenville N.C.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Geo. S. Nelson 1348 N. Calhoun St</b>			

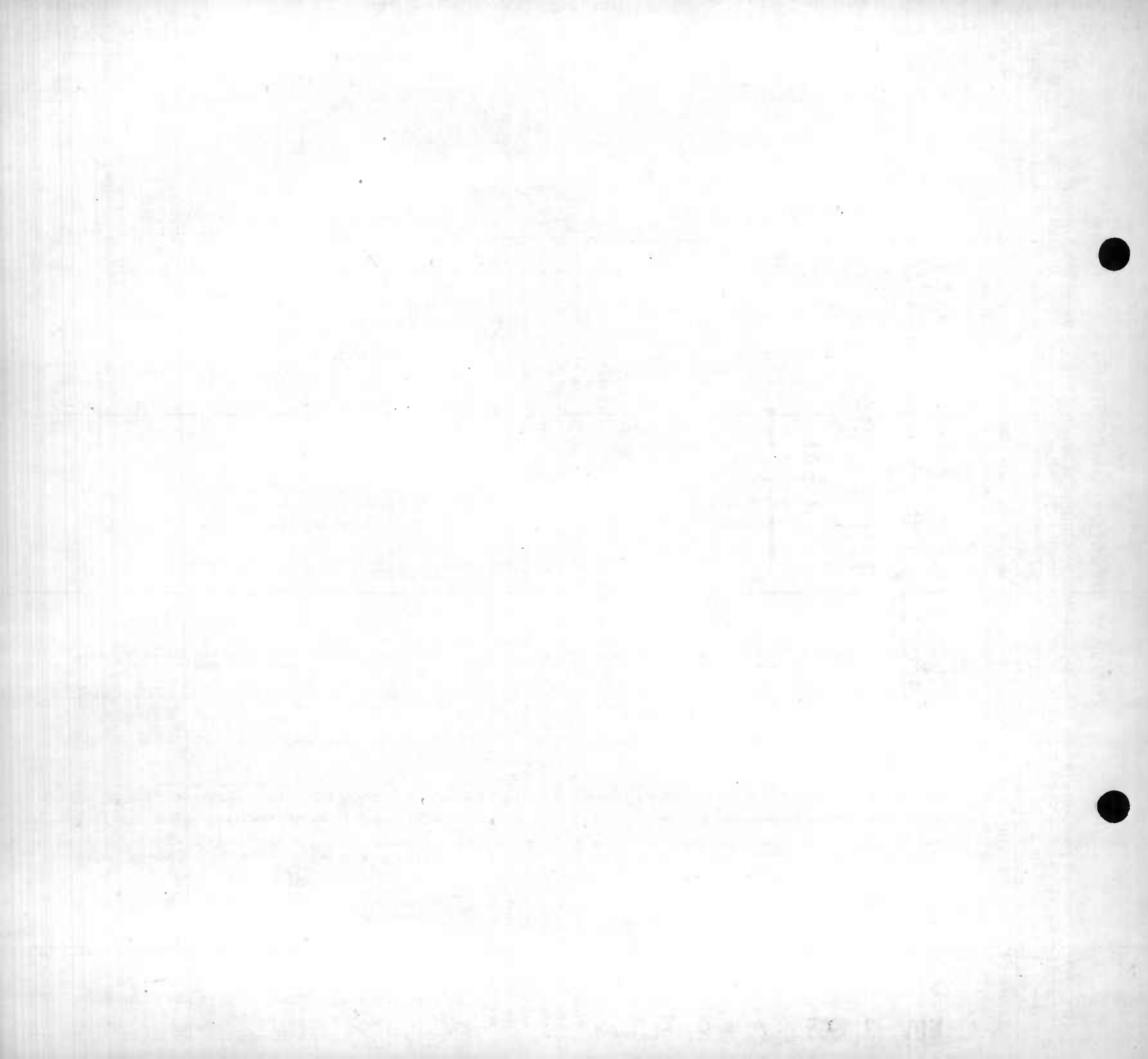
WALLACE B. DILLON

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11107				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11107	
1. NAME OF DECEASED (Type or Print) Cora Gladden				2. DATE AND HOUR OF DEATH October 29, 1965 4:15a.m.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 15-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 2124 Pennsylvania Avenue					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH May 18, 1894	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT James V. Gladden-son		ADDRESS same Pa. 8-0713			
18. 5-84 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. frequent attacks with nausea				CAUSE OF DEATH (A) DUE TO pneumonia (B) DUE TO cholelithiasis with cholecystitis (chronic) (C)		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from August 24, 1965 to October 29, 1965, that (I) (we) last saw the deceased alive on October 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>[Signature]</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Oct. 29, 1965			
23C. PHYSICIAN'S NAME (Type) HARRIS R. G. AUP.				23D. ADDRESS M.D. 1514 Division St. Baltimore, Md. 21217					
24A. BURIAL REMOVAL (Specify) Burial		24B. DATE 11-1-65		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR George H. Kiker		ADDRESS 1348 N. Calhoun St			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 11108	
BIRTH NO. 65 11108		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Rose L. <del>Earnest</del> (Earnest)		2. DATE AND HOUR OF DEATH 10/27/65 6:30 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2047 Annapolis Rd.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 25-33 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2047 Annapolis Rd.			
5. SEX Fe	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Nov. 19, 1889	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm. Cragg			14. MOTHER'S MAIDEN NAME Rosa				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS Same	
18. <u>4221</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Bronchus Pneumonia Central arteriosclerosis (B) DUE TO Right Hemiplegia (C) Generalized Arteriosclerosis and cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 10/24/65  1964  10yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5:10 1964 to 10:27 1965, that (I) (we) last saw the deceased alive on 10/27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph G. LAUKAITIS MD				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/27/65	
23C. PHYSICIAN'S NAME (Type) JOSEPH G. LAUKAITIS MD				23D. ADDRESS 679 Washington and Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/30/65		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 237 Patapsco Ave.	



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NOV 1 1955

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11109				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11109	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) Norma J. Bremer						Oct. 29, 1965 1 7:50 A.M.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HDSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
4200 Somerset Place				Maryland		27-14	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				4200 Somerset Place			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
female	white	widowed	Jan. 15, 1898	67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		Home		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward B. Johnson				Carrie I. Catrup			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Mrs. Ralph F. Truitt		4410 Marble Hall Rd.	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO		1 wk	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Central Vascular Thrombosis			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pneumonia		2 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 49 to Oct 29 1965.				that (I) (we) last saw the deceased alive on Oct 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
Francis W. Gluck				10/29/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Dr. Francis Gluck		M.D. 100 W. University Parkway					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Nov. 1, 1965		Lorraine		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 1 1965		Robert E. Taylor		Mitchell-Wiedefeld Home			

NOV 1 1951

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 11110</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11110</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>ELLIS THELMA L</b>		<b>10-28-65</b>		<b>2:20 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> (If not in hospital or institution, give street address or location)			A. STATE <b>MD</b>		
			B. COUNTY <b>23-02</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>1615 S CHARLES</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-14-01</b>	9. AGE (In years lost birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>CHARLES PLUMMER</b>			14. MOTHER'S MAIDEN NAME <b>SARAH TURBUTT</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>17570 I</b> <b>CAUSE OF DEATH</b> <b>Diffuse Carcinomatosis, adenocarcinoma of ovaries</b> DUE TO <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 13 1965</b> to <b>OCT 28 1965</b> , that (I) (we) last saw the deceased alive on <b>OCT 28 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Steve C. Papastephanou</b>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <b>STEVE C PAPASTEPHANOU</b>			23D. ADDRESS <b>M.D. CATON &amp; WILKENS AVE. BALTIMORE MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>B</b>	24B. DATE <b>11/1/64</b>	24C. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltz</b>		25C. FUNERAL DIRECTOR ADDRESS <b>McCully - 1306 Fort Ave.</b>	

Office Memorandum  
Department of Justice

John F. Thompson

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 11111		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11111	
BIRTH NO. 65 11111		CERTIFICATE OF DEATH		October 30, 1965 3:50 P.M.	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Evans, Mat NMI		2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		A. STATE Maryland B. COUNTY 17-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 564 Orchard St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/20/96	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry, Evans			
14. MOTHER'S MAIDEN NAME Catherine Levenor		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/30/18-12/10/18			
16. SOCIAL SECURITY NO. 215 05 3863		17. INFORMANT ADDRESS Veterans Hospital, Balto., Md. 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Carcinoma Of Esophagus DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pulmonary Tuberculosis Active		10 Months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from March 4, 19 65 to October 30, 19 65, that (X) (we) last saw the deceased alive on October 30, 19 65 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Young E. Chun				23B. DATE SIGNED 10/30/65	
23C. PHYSICIAN'S NAME (Type) Young E. Chun				23D. ADDRESS Veterans Hospital, Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-3-65		24C. NAME OF CEMETERY or CREMATORY Balto. NAT.	
24D. LOCATION (City, town, or county) Balto.		24E. LOCATION (State) Md			
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR Robert E. Farley, Md		25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett, 1707 Laurens St., Balto. Md.	

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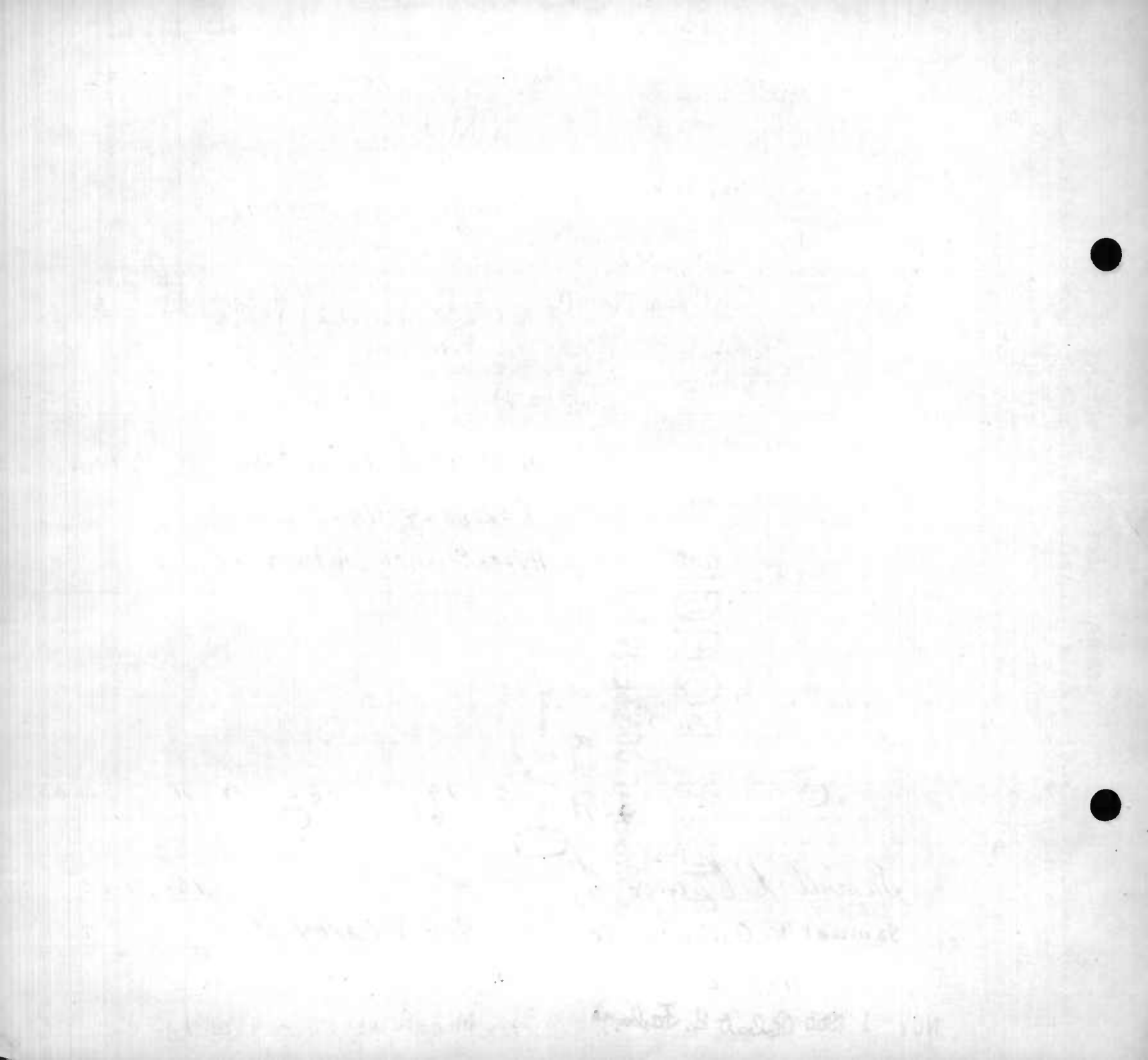
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 11112	
BIRTH NO. 65 11112		M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>LINWOOD MATTHEWS</b>				2. DATE AND HOUR OF DEATH <b>10-28-65 2:32 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Md.</b>		B. COUNTY <b>15-09</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>			
				D. STREET ADDRESS (If rural, give location) <b>3103 Wolcott Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>7-23-1899</b>	9. AGE (in years last birthday) <b>66</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Gas + Elec. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Greensburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Syvester Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Rachel</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-3387</b>		17. INFORMANT <b>Mr. Noble Matthews - 3805 Bonner Rd.</b>		ADDRESS	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Heart Disease</b> <b>Hypertension Arteriosclerotic</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 Hour</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (his hospital) attended the deceased from <b>2-19-62</b> to <b>9-11-65</b> , that (I) (we) last saw the deceased alive on <b>9-11-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Samuel R. Owings, Jr.</b>				M.D. Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-29-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Samuel R. Owings, Jr.</b>				23D. ADDRESS <b>909 N. Carey St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-1-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farnham</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON + Dye II - 1701 LAURENS ST.</b>			



65 11113

BALTIMORE CITY HEALTH DEPARTMENT

65 11113

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM WHITE

2. DATE AND HOUR PRONOUNCED DEAD

October 28, 1965

10:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Glen Burnie

D. STREET ADDRESS (If rural, give location)

7345 Furnace Branch Road

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

RICHARD WHITE

14. MOTHER'S MAIDEN NAME

ANNIE RILEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Evelyn White - 7345 Furnace Br. Rd.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 29, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/1/65

23C. NAME OF CEMETERY or CREMATORY

Mt Zion Church

23D. LOCATION

(City, town, or county)

magdaly md

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Marshall P. Hays 638 N. Gilman

ADDRESS

VALLEY HORSE

WAS CONSTANT

THE A

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 11114					BIRTH NO.		65 11114		
M.E. CASE NO.					1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH		
(Type or Print) <b>BAUBLITZ, CLARA A</b>					<b>10 23 65</b>		<b>8:05 A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
<b>40 ST AGNES HOSPITAL</b>					<b>MARYLAND</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					<b>BALTIMORE</b>				
					D. STREET ADDRESS (If rural, give location)				
					<b>1801 WOODSIDE AVE</b>				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
<b>FEMALE</b>		<b>WHITE</b>		<b>WIDOWED</b>		<b>11 6 79</b>		<b>85</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<b>NONE</b>		<b>None</b>		<b>MARYLAND</b>			<b>USA</b>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
<b>MATTHEW JOHNSON</b>					<b>SALLIE MOORE</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
<b>no</b>							<b>ST AGNES HOSP RECORDS</b>		
18. <b>420.1 I</b>					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) <b>Generalized Atherosclerosis</b>				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					(B) <b>Myocardial Infarction</b>				
ANTECEDENT CAUSES					(C) <b>Congestive Failure</b>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
<b>NO</b>				<b>NO</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10 5 1965</b> to <b>10 23 1965</b> , that (I) (we) last saw the deceased alive on <b>10 23 1965</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
<b>John C Healy</b>								<b>10/23/65</b>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
<b>JOHN C HEALY</b>									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<b>Burial</b>		<b>10-26-65</b>		<b>Long Hill Cemetery</b>		<b>Laurel, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<b>NOV. 1 1965</b>		<b>Robert E. Fairbanks</b>		<b>Robert E. Fairbanks</b>		<b>Laurel, Md.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 11115				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11115	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				BEARD, JOHN I			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
ST AGNES HOSPITAL				MARYLAND Howard			
5. SEX				6. DATE AND HOUR OF DEATH			
MALE				10-28-65 12:15 P. M.			
7. RACE				8. DATE OF BIRTH			
WHITE				12-6-13			
9. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				10. AGE (In years lost birthday)			
MARRIED				51			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
MARYLAND				U.S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN Beard				MAUDE VOGT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
YES WORLD WAR 2				234 01 6752			
17. INFORMANT				ADDRESS			
CATON AVES. 21229				ST AGNES HOSPITAL RECORDS, WILKINS AND			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) - SUBARACHNOID AND INTRA-VENTRICULAR HEMORRHAGE.			
ANTECEDENT CAUSES				(B) - ANEURYSM CONGENITAL, SUSPECTED.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
NONE				NO			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NONE							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10-26 1965 to 10-28 1965, that (I) (we) last saw the deceased alive on 10-28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				21F. HOW DID INJURY OCCUR?			
23A. SIGNATURE				23B. DATE SIGNED			
Thamnoon Penroach M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>				10-28-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
THAMNOON PENROACH M.D.				ST. AGNES HOSPITAL, BALTIMORE 29, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				11-1-65			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Rose Hill Cem.				Hagerstown, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
NOV 1 1965				Robert E. Fickling			
25C. FUNERAL DIRECTOR				ADDRESS			
Nathaniel Penroach				Charles M.D.			



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11116				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11116			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
MEISER, MARGARET R.				10-29-65				6:20A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY			
ST. AGNES HOSPITAL				MARYLAND				ANNE ARUNDEL			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
				PASADENA				52-00			
				D. STREET ADDRESS (If rural, give location)							
				BOX 117 RT 5							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days	
FEMALE		WHITE		MARRIED		6-19-05		60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
HOUSEWIFE								MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
LEROY ROBINSON				HATTIE M. MOORE							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
								ST. AGNES RECORDS--CATON & WILKENS AVES.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
170X I				Carcinoma of the breast							
ANTECEDENT CAUSES				DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
O				NO							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) 1Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 23 19 65 to OCTOBER 29 19 65, that (I) (we) last saw the deceased alive on OCTOBER 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
George Edmund Engelke M.D.				10-29-65							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
GEORGE EDMUND ENGELKE				ST. AGNES HOSPITAL CATON & WILKENS AVE							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		Nov. 1, 1965		London Park Cem.		BALTO. Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
NOV 1 1965		Robert E. Tarkenton		G. TRUMAN SCHWAB		3542 FARRINGTON AVE (29)					

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		65 11117 Chapman, Fred		2. DATE AND HOUR OF DEATH October 29, 1965 11:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21213 D. STREET ADDRESS (If rural, give location) 2113 E. Preston Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-26-1911	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY Luby Chev. 3300 E. Monument St.		11. BIRTHPLACE (State or foreign country) Ayden, N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NOAH Chapman			
14. MOTHER'S MAIDEN NAME MARTHA MORRIS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT LOSSIE Chapman - 2113 E. Preston St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH Septicemia due to - Cellulitis of left lower extremity		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION Oct. 29, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cellulitis, left leg		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 29, 1965 to October 29, 1965, that (I) (we) last saw the deceased alive on October 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D.R. Govinda Rao		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Oct. 30, 1965	
23C. PHYSICIAN'S NAME (Type) D. R. Govinda Rao		23D. ADDRESS 1400 North Caroline Street, 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-2-1965		24C. NAME OF CEMETERY or CREMATORY Mt. CALVARY	
24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL Co., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MARSHALL W. JONES, JR. 1735 ADDRESS HARFORD AVE.			

It was a very  
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BIRTH NO. 65 11118		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 65 11118	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LEROY HERMANN BARRETT		2. DATE AND HOUR PRONOUNCED DEAD 10/27/65 10:30 p. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland 21205 B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-34 D. STREET ADDRESS (If rural, give location) 929 Rodman xxx Way			
FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospitals					
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced	8. DATE OF BIRTH 8/19/15	9. AGE (In years last birthday) 50	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY E. Stress Contr.		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Jesse Barrett		14. MOTHER'S MAIDEN NAME Mattie Cunningham			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.2		16. SOCIAL SECURITY NO. 216-16-6329		17. INFORMANT Wm. J. Barrett, Brother, above	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E900.0 Massive pulmonary embolism complicating craniocerebral injury		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CAUSING CAUSES OF DEATH? yes					
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 929 Rodman Ave. 26-34	
21D. TIME OF INJURY (APPROX.) 10 20 65 ?		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? apparently fell down steps	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/28/65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 11/31/65		23C. NAME of CEMETERY or CREMATORY Mountain View Cemetery	
23D. LOCATION (City, town, or county) Blacksburg, S. C.		(State)			
24A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.		24C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	
24D. ADDRESS					

WILLIAM  
B. BROWN  
JUNIOR  
1915

1915

WILLIAM B. BROWN

WILLIAM B. BROWN

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WILLIAM B. BROWN

WILLIAM B. BROWN

WILLIAM B. BROWN



65 11119

BALTIMORE CITY HEALTH DEPARTMENT

65 11119

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT R. KNIGHT

2. DATE AND HOUR PRONOUNCED DEAD

October 28, 1965

9:15 P.<sup>M.</sup>

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5917 Radecke Ave. Apt. E

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

6/26/1920

9. AGE (in years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William D. Knight

14. MOTHER'S MAIDEN NAME

Katherine Neetcke

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

yes

W.W.2

16. SOCIAL  
SECURITY NO.

215-09-0691

17. INFORMANT

ADDRESS

Milred Johns Knight, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of head  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

5917 Radecke Ave. Apt. E

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10-25-65 3:00 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 29, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/30/65

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

ADDRESS

WALTER E. BROWN

RECEIVED

20-00-00-01

20-00-00-01

NOV 1 1957

## CERTIFICATE OF DEATH

Registered No.

65 11120

BIRTH NO.

65 11120

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Lottie Bloome or Blome

2. DATE AND HOUR OF DEATH

October 27, 1965

6:50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland, #212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

516 N. Lakewood Avenue, #21231

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Single

8. DATE OF BIRTH

May 9, 1884

9. AGE (In years  
last birthday)  
81If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Home-maker

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore  
Maryland12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH, 4940 Eastern Avenue, #21224

18.

053.41

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Pneumonia with probable Septicemia  
DUE TO

7 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Uremia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from September 15, 19 65 to October 27, 19 65,  
that (I) (we) last saw the deceased alive on October 27, 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. A. Dennis

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

October 27, 1965

23C. PHYSICIAN'S  
NAME (Type)

M. A. Dennis

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md., #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/30/65

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 1 1965

Robert E. Taylor

Schimunek Funeral Home, Inc.  
2601 E. Madison St.

FUNERAL DIRECTOR: IMPORTANT

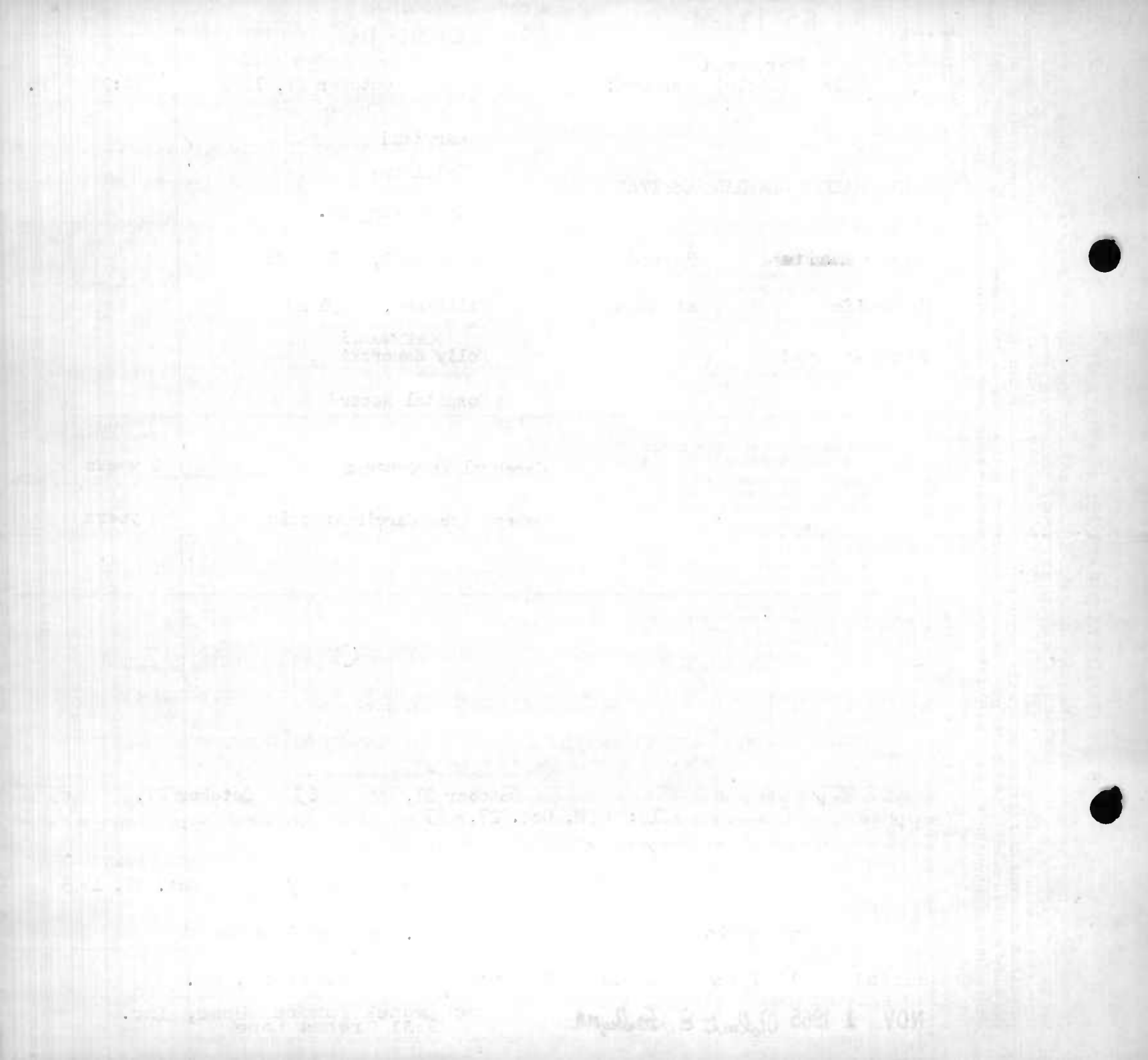
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11121</b>	
BIRTH NO. <b>65 11121</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Margaret Ella (Stein) Weredyck</b>		2. DATE AND HOUR OF DEATH <b>October 27, 1965 10:20 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>NORTH CHARLES GENERAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>8413 Avery Rd.</b>			
5. SEX <b>Female</b>	6. RACE <b>Whiten</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>November 3, 1893</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Frank Jaworski</b>		14. MOTHER'S MAIDEN NAME <b>Karwacki Molly Kaworski</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Hospital Record</b>	
18. <b>199.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Generalized Carcinomatosis</b> DUE TO		<b>6 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <input type="radio"/>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="radio"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 21, 1965</b> to <b>October 27, 1965</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>10:20 PM, Oct. 27, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <b>Memio Moraga Jr.</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>Oct. 27, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ray Rangle</b>		23D. ADDRESS <b>St. Paul and 30th Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/1/65</b>	24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11122</b>	
CERTIFICATE OF DEATH					
BIRTH NO. <b>65 11122</b>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>STANISLAV KLAPKA</b>	
2. DATE AND HOUR OF DEATH <b>Oct. 27, 1965</b>		10:15 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>7-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>718 N. Curley St., Baltimore, Md., 21205</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>718 N. Curley St.</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>8/6/1886</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet-Maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Knipp &amp; Sons</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>unknown</b>			
14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>215-03-7901</b>		17. INFORMANT ADDRESS <b>Anna Sevejnoha Klapka, wife, above</b>			
18. <b>331X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cerebral Hemorrhage</b> (B) <b>Left side Paralysis</b> (C) <b>Blindness Hemiparesis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>June 1965</b> <b>June 1965</b> <b>?</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>June 1965</b> to <b>Oct 27 1965</b> that (I) (we) last saw the deceased alive on <b>Oct 27 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louis F. Klimes</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Louis Klimes</b>		23D. ADDRESS <b>4814 Bowleys Lane</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/30/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bohemian National Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fashy</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 2601 E. Madison St.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 2em;">65 11123</span>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH <span style="font-size: 2em;">X</span>		Registered No. <span style="font-size: 2em;">65 11123</span>	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">DOLLY VICTORIA HUMBERTSON</span>				OCTOBER 26, 1965   7:02P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em;">ST. AGNES HOSPITAL</span>		(If not in hospital or institution, give street address or location)		A. STATE <span style="font-size: 1.5em;">MARYLAND</span>		B. COUNTY <span style="font-size: 1.5em;">Allegany</span>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">CUMBERLAND</span>		<span style="font-size: 1.5em;">67-028</span>	
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.5em;">1500 FREDERICK STREET</span>			
5. SEX <span style="font-size: 1.5em;">FEMALE</span>	6. RACE <span style="font-size: 1.5em;">WHITE</span>	7. MARRIED, NEVER MARRIED <span style="font-size: 1.5em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.5em;">7-26-23</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">42</span>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">MARYLAND</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">U.S.</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">JAMES BOGGS</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">TACY ROBINETTE</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">218-218-7647</span>		17. INFORMANT <span style="font-size: 1.5em;">ST. AGNES RECORDS WILKENS AND CATON AVE</span>		ADDRESS	
18. <span style="font-size: 2em;">330X1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 2em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH <span style="font-size: 1.5em;">Ruptured cerebral aneurysm.</span>		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION		CERTIFICATION APPROVED BY <span style="font-size: 1.5em;">[Signature]</span> CHIEF OF MEDICAL EXAMINER <span style="font-size: 1.5em;">2/24/66</span>					
19A. DATE OF OPERATION <span style="font-size: 1.5em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">YES</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.5em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <span style="font-size: 1.5em;">X</span> (this hospital) attended the deceased from <span style="font-size: 1.5em;">OCTOBER 24</span> 19 <span style="font-size: 1.5em;">65</span> to <span style="font-size: 1.5em;">OCTOBER 26</span> 19 <span style="font-size: 1.5em;">65</span> , that <span style="font-size: 1.5em;">X</span> (we) last saw the deceased alive on <span style="font-size: 1.5em;">OCTOBER 26</span> 19 <span style="font-size: 1.5em;">65</span> and that in <span style="font-size: 1.5em;">X</span> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <span style="font-size: 1.5em;">X</span> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">Steve P. Papastephanou</span>						23B. DATE SIGNED <span style="font-size: 1.5em;">10/26/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">STEVE PAPASTEPHANOU</span>						23D. ADDRESS <span style="font-size: 1.5em;">M.D.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>		24B. DATE <span style="font-size: 1.5em;">10/29/65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.5em;">Pleasant Grove Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Cumberland Allegany Co Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">NOV 1 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Farkner</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.5em;">Ruth E. Silcox Cumberland Maryland</span>			

1950-1951

1950-1951

1950-1951

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1950-1951

*Handwritten signature*

1950-1951

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1950-1951

*Handwritten signature*

1950-1951

1950-1951

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 11124	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
HAZEL E FEDOCK			10/29/65 6:01 p. m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
13 South Baltimore General			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1229 Battery Ave.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 Yr. Months, Days
female	white	M.	6-22-18	47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
JEANISTEES		Raleigh Co		TENN.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles J. Collins			Barbara Kolton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Family - Jane
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
E 416X			Rheumatic heart disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER		DATE SIGNED
Werner U. Spitz					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER		
Werner U. Spitz, M.D.					
23A. BURIAL CREMATION, REMOVAL (Specify)			23B. DATE		23C. NAME OF CEMETERY or CREMATORY
B			11/2/65		Cedar Hill
24A. DATE REC'D BY HEALTH DEPT.			24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR
NOV 1 1965			Robert E. Fairbank		McGuire - 130 E Fort St



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11125		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11125	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>LULA-TURNER</b>		2. DATE AND HOUR OF DEATH <b>10/31/65 5:30 a.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>PARK HILL NURSING HOME</b> <b>1802 EUTAW PLACE</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>2-3-01</b> C. CITY OR TOWN <b>BALTIMORE</b> D. STREET ADDRESS <b>104 WILBURNETT ST.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Sept 25 1877</b>	9. AGE (In years last birthday) <b>88</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT Home</b>	11. BIRTHPLACE (State or foreign country) <b>Essex Co., VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>LELAND CARNEAL</b>			14. MOTHER'S MAIDEN NAME <b>VIRGINIA-FAULKNER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Mrs. LULA L. LITZ</b> <b>117 W. OSTEAD ST.</b> ADDRESS <b>BALTO, MD 21230</b>		
18. <b>334 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>		CAUSE OF DEATH (A) <b>Cerebrovascular Art. Sclerosis</b> DUE TO (B) <b>Generalized Art. Scl.</b> DUE TO (C) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sev. years</b> <b>years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 24 1958</b> to <b>Oct 31 1965</b> , that (I) (we) last saw the deceased alive on <b>Oct 29 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louis V. Blum, M.D.</b>				23B. DATE SIGNED <b>10/31/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis V. Blum, M.D.</b>				23D. ADDRESS <b>3502 W. Rogers Ave Balto, Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Nov 13-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>CEDAR HILL Cemetery, BROOKLYN-BA, Co., Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO, MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>CURTIS E. EVANS</b> <b>1400 S. CHARLES ST. BALTO, MD 21230</b>			

CURTIS E. EVANS

James Wilson M.D.  
James Wilson M.D.

3705 N. Rogers Ave. N.W.  
N.W. 3705  
N.W. 3705  
N.W. 3705

11-20-11

James Wilson M.D.

3705 N. Rogers Ave. N.W.

James Wilson M.D.

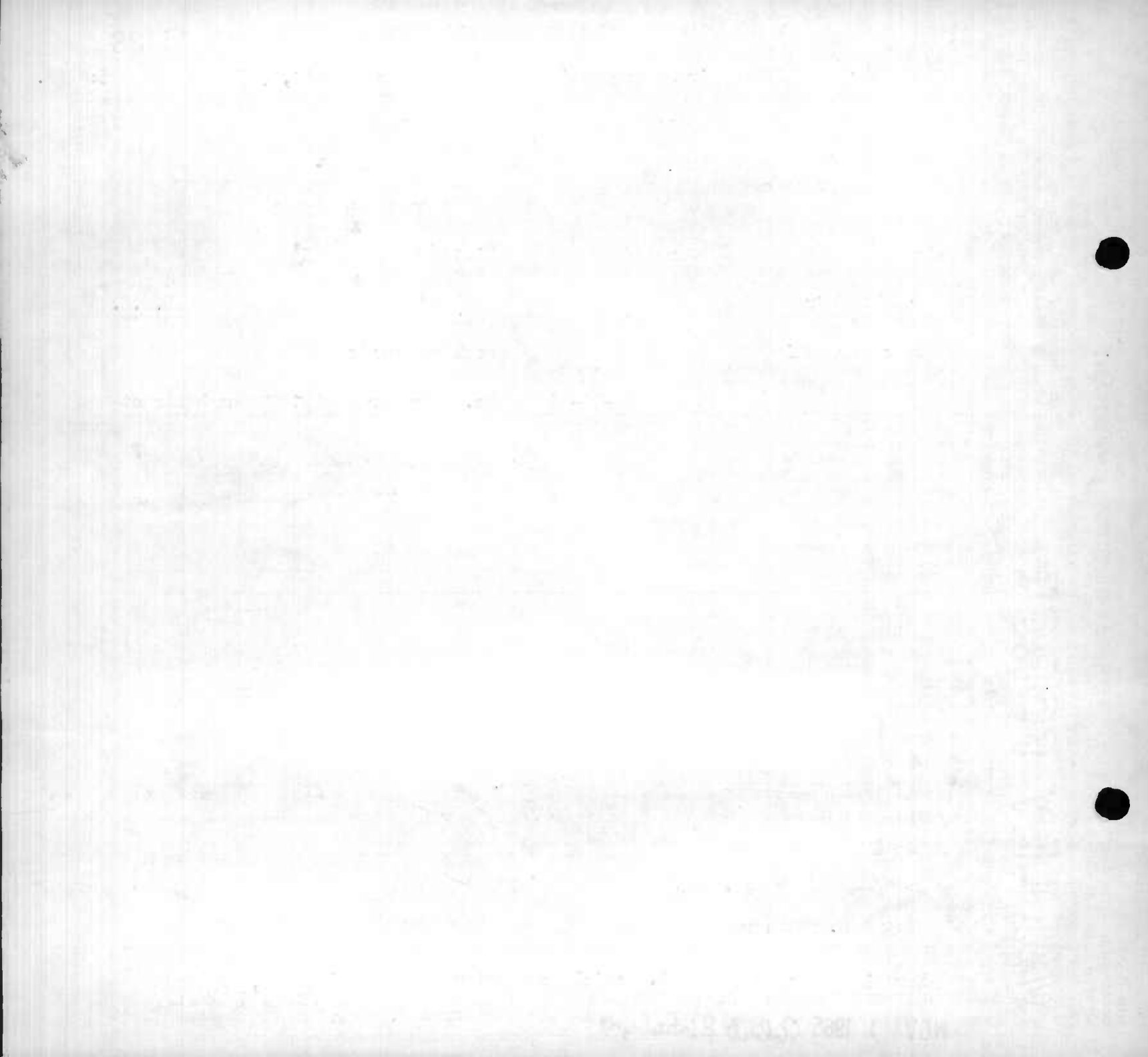
3705 N. Rogers Ave. N.W.  
N.W. 3705  
N.W. 3705  
N.W. 3705



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

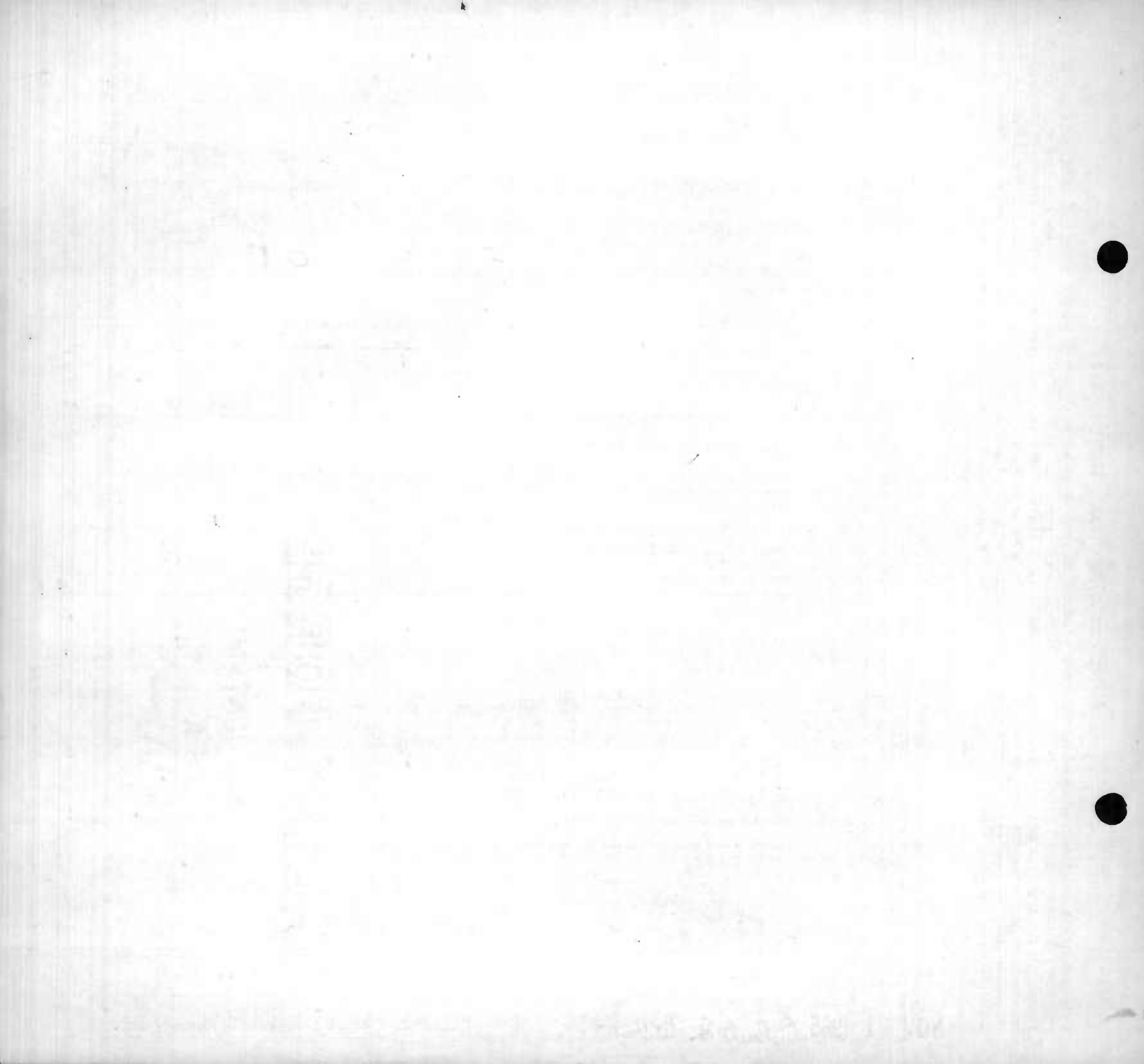
BIRTH NO. 65 11126				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11126	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Joseph Frank Sarnecki		October 31, 1965 5: P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
1802 Gough Street		At Home		Maryland		202	
5. SEX				6. RACE			
Male				White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
Married				3/14/97			
9. AGE (In years last birthday)				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
68				Chauffeur			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Poland				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Louis Sarnecki				Pauline Dranka			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				216-01-2488		Mrs. Agnes Sarnecki 1802 Gough Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				?			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Sept 19 65 to Oct. 31 19 65, that (I) (we) lost saw the deceased olive on Oct 27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Sylvan D. Goldberg						Nov 1, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Sylvan D. Goldberg				M.D. 420 Medical Arts Building			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/4/65		St. Stanislaus Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 1 1965		Robert E. Falsky		George A. Weber		705 South Ann Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11127		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11127	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ODANIELL, WILLIAM FRANKLIN			2. DATE AND HOUR OF DEATH 10/29/65 6:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 25-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 7 PATAPSCO AVE		
5. SEX MALE	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/18/05	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRATE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME UNKNOWN Wm. O'Daniell			14. MOTHER'S MAIDEN NAME UNKNOWN Mary Claudie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MRS. MARGARET O'DANIELL SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of the lungs w/ metastases (B) DUE TO (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/8 1965 to 10/29 1965, that (I) (we) last saw the deceased alive on 10/29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Minita Suarez				23B. DATE SIGNED 10/29/65	
23C. PHYSICIAN'S NAME (Type) MINITA SUAREZ		23D. ADDRESS M.D. FRANKLIN - SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-1-65	24C. NAME of CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home Dundalk, Md.	



# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department																			
BIRTH NO. 65 11128					CERTIFICATE OF DEATH					Registered No. 65 11128									
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <b>ARTHUR F. GAUER</b>					2. DATE AND HOUR OF DEATH <b>445 AM 10/30/65</b>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSP</b>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>									
										D. STREET ADDRESS (If rural, give location) <b>13 LESLIE AVE 21236</b>									
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>12/13/04</b>		9. AGE (In years last birthday) <b>60</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES REPRESENTATIVE UNK</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>UNK</b>					11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>JOHN F. GAUER</b>										14. MOTHER'S MAIDEN NAME <b>ANNA BAEHR</b>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>					16. SOCIAL SECURITY NO. <b>UNK</b>		17. INFORMANT <b>MRS A F GAUER</b>					ADDRESS <b>5/A</b>							
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>coronary Arterio sclerosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial infarction, acute diffuse, posterior wall and septum.</b>										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Bruts</b>																			
19A. DATE OF OPERATION <b>2</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>YES</b>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>ye</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>11 PM 10/12</b> 19 <b>65</b> to <b>445 AM 10/30</b> 19 <b>65</b> , that <del>(H)</del> (we) last saw the deceased alive on <b>445 AM 10/30</b> 19 <b>65</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(H)</del> (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <b>Robert N. Whitlock</b>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>10/30/65</b>				
23C. PHYSICIAN'S NAME (Type) <b>ROBERT N. WHITLOCK</b>										23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>11-2-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>					24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>							
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>					25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>					25C. FUNERAL DIRECTOR <b>Ullrich Funeral Home</b>					ADDRESS <b>Baltimore, Md.</b>				

JOHN T. GIBBS

WAGE WHITE

JOHN T. GIBBS

JOHN T. GIBBS

JOHN T. GIBBS

JOHN T. GIBBS

JOHN T. GIBBS

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JOHN T. GIBBS

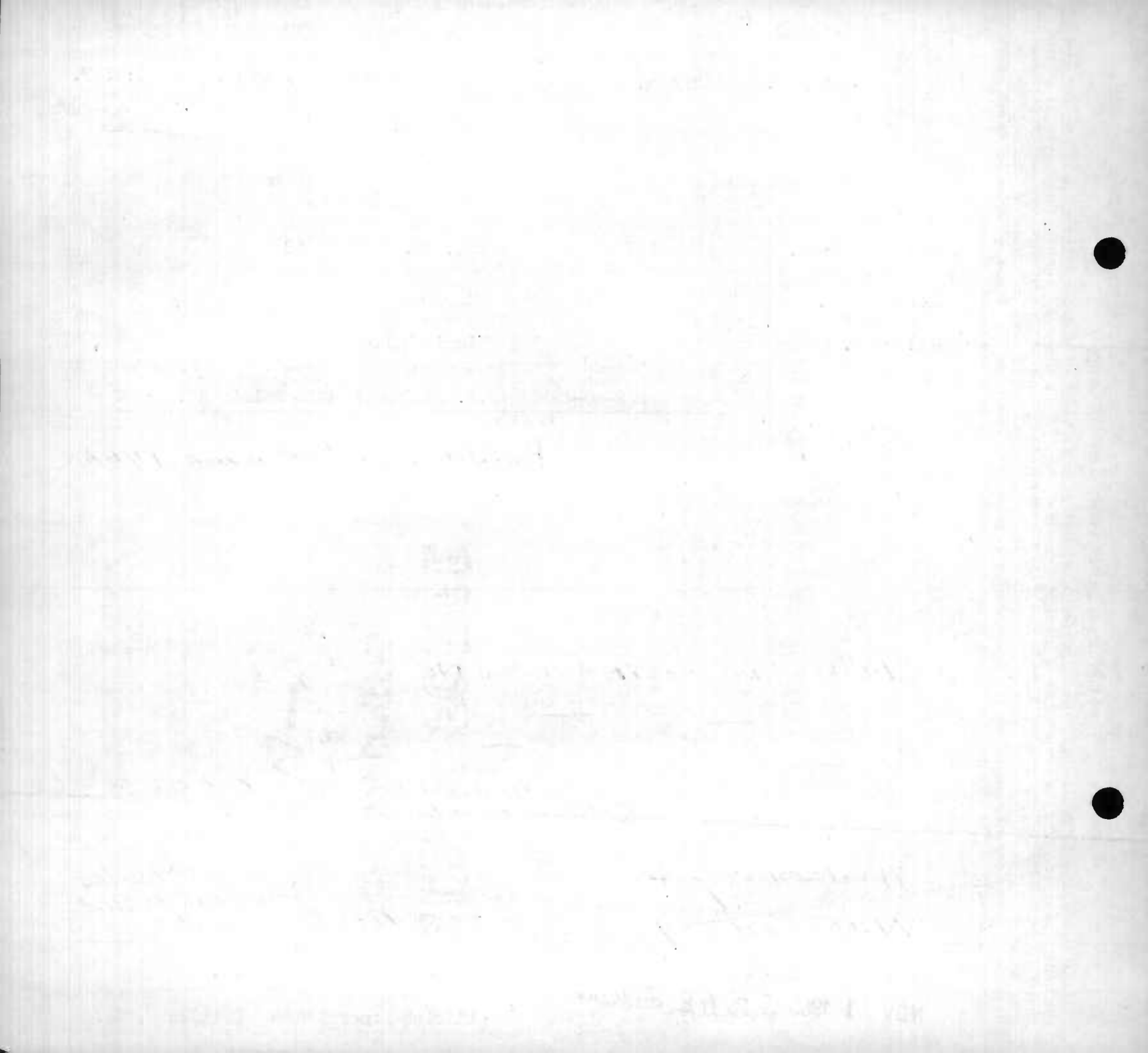
JOHN T. GIBBS

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11129				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11129	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Dorothy Ellis Atkinson</b>				2. DATE AND HOUR OF DEATH <b>October 30, 1965</b> <b>8:15 P.</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4210 Belair Road</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-01</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>4210 Belair Road</b>			
5. SEX <b>Female</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>	8. DATE OF BIRTH <b>Sept. 22, 1907</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Willard W. Welsh</b>				
14. MOTHER'S MAIDEN NAME <b>Minnie McDonald</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <b>225-46-3911</b>			17. INFORMANT ADDRESS <b>F.J. Atkinson 4210 Belair Rd. 21206</b>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOGENIC CARCINOMA 1 YEAR</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>			
19A. DATE OF OPERATION <b>8/15/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diagnostic Aspiration</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 5th 1965</b> to <b>October 30 1965</b> , that (I) (we) last saw the deceased alive on <b>October 30 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>W. M. Conway</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/30/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. M. CONWAY</b>				23D. ADDRESS <b>8358 Loch Raven Blvd, Towson, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-2-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Ullrich Funeral Home Baltimore, Md.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11130</b>	
BIRTH NO. <b>65 11130</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FRYE, ROY L.</b>		2. DATE AND HOUR OF DEATH <b>10-30-65 about 1:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Home: 4656 York Road</b>		A. STATE <b>Maryland</b> B. COUNTY <b>27-11</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
		D. STREET ADDRESS (If rural, give location) <b>4656 York Road</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>4-13-16</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist employed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Glenn L. Martin</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Lonnie Cameron Frie</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Bryant</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>226-03-8958</b>		17. INFORMANT <b>E.S. Ellis</b> ADDRESS <b>The Union Memorial Hosp.</b>	
18. <b>199.2.1</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Terminal case of</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Squamous cell Carcinoma</b>			
		(C) <b>of lung + Perianal region</b>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>last month in the hospital</b>		that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>E.S. Ellis</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/30/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>E.S. Ellis</b>		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/1/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Rockbridge Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Rockbridge County, Virginia</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>John A. Moran Inc.</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>3000 E. Baltimore St.</b>		25D. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25E. NAME OF REGISTRAR <b>John A. Moran Inc.</b>	



BALTIMORE CITY HEALTH DEPARTMENT

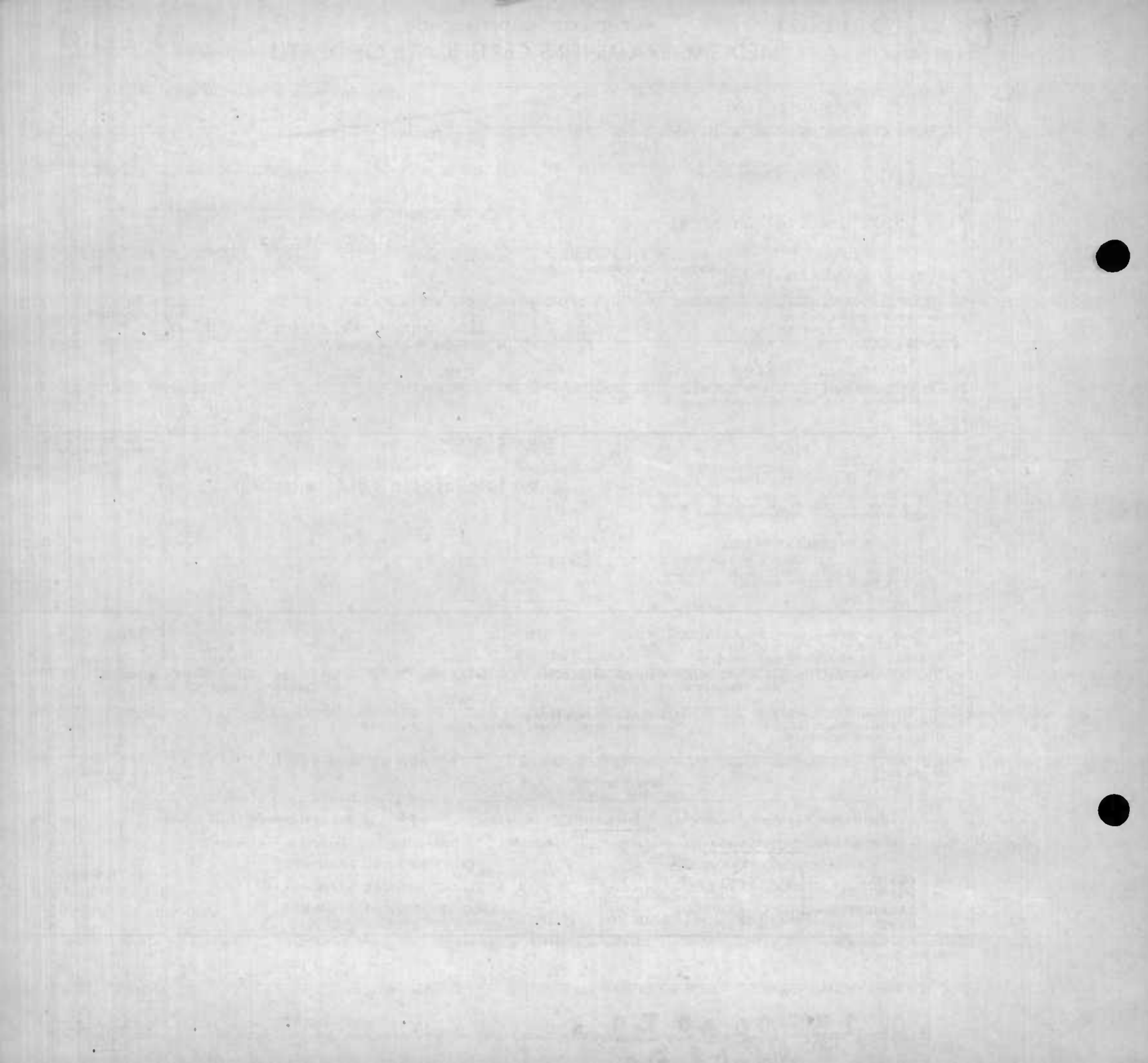
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 65 11131

BIRTH NO. 65 11131

M.E. CASE NO. D-400

1. NAME OF DECEASED (Type or Print) <b>ROLAND DAILEY</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>October 28, 1965 4:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>208 Bosley Avenue</b>	
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>May 14, 1913</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>52</b>
13. FATHER'S NAME <b>Edward R. Dailey</b>		14. MOTHER'S MAIDEN NAME <b>Nanny L. Easton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT <b>Mrs. Altha E. Dailey</b>		ADDRESS <b>208 Bosley Ave</b>	
18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH (A) <b>Arteriosclerotic cardiovascular disease</b> DUE TO  (B) <b>DUE TO</b>  (C) <b>DUE TO</b>  INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21G. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>October 29, 1965</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23B. DATE <b>11/1/1965</b>	23C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		24B. NAME OF REGISTRAR <b>John A. Moran Inc.</b>	
24C. FUNERAL DIRECTOR <b>John A. Moran Inc.</b>		ADDRESS <b>3000 E. Baltimore St.</b>	

VS 151-REV. 1/1/65

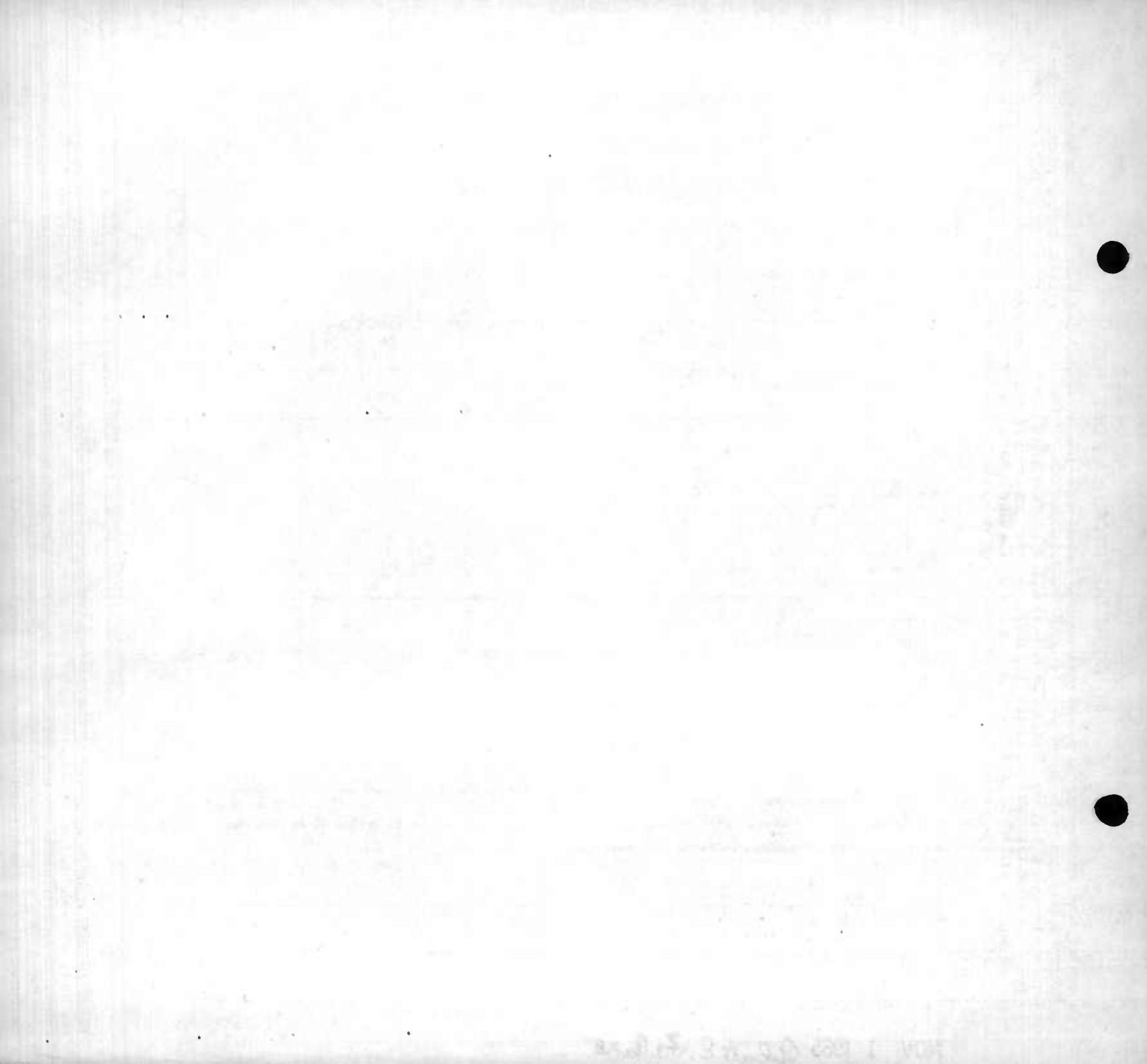


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11132</b>	
BIRTH NO. <b>65 11132</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Sue D. McShane</b>		2. DATE AND HOUR OF DEATH <b>Oct 30, 1965 7:50 PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mercy Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>United States</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>6-02</b> D. STREET ADDRESS (If rural, give location) <b>102 N. Lake wood Ave</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>2/24/88</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Dennis</b>		14. MOTHER'S MAIDEN NAME <b>Anne E. Finnegan</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT <b>Mr. John F. Dennis</b> ADDRESS <b>135 N. Belwood Ave.</b>	
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Lung Cancer</b>		CAUSE OF DEATH (A) DUE TO <b>Lung Cancer</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>None</b>			
		(C) <b>None</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>None</b>			
19A. DATE OF OPERATION <b>No</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>IN</b> (this hospital) attended the deceased from <b>Oct 22</b> 19 <b>65</b> to <b>Oct 30</b> 19 <b>65</b> , that <b>IN</b> (we) last saw the deceased alive on <b>Oct 30</b> 19 <b>65</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Wen-Ruy Ko</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>Oct 30 '65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Wen-Ruy Ko</b>		23D. ADDRESS <b>Mercy Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/2/1965</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <b>John A. Moran Inc. 3000 E. Baltimore St.</b>	

VS NOV 1 1965





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11133		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11133	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>LATCHFORD, VIOLET L.</b>		2. DATE AND HOUR OF DEATH <b>OCTOBER 26, 1965   2:10P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>28-04</b> D. STREET ADDRESS (If rural, give location) <b>201 SOUTH BEECHFIELD AVE. APTC</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>7-14-10</b>	9. AGE (In years lost birthday) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P TELEPHONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HERSCHEL E. KRAFT (DEC'D)</b>			
14. MOTHER'S MAIDEN NAME <b>CATHERINE EWALT (DEC'D)</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NONE none</b>			
16. SOCIAL SECURITY NO. <b>212-05-1931</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL RECORDS</b>			
18. <b>581.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Negative Coma</b> DUE TO (B) <b>Encephalitis of the Liver</b> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 26 19 65</b> to <b>OCT 26 19 65</b> , that (I) (we) last saw the deceased alive on <b>OCT 26 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Miguel Heredia</b>		23B. DATE SIGNED <b>10-26-65</b>		23C. PHYSICIAN'S NAME (Type) <b>MIGUEL HEREDIA</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>OCT 29, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sterling Funeral Estate 736 Edm. Av. Catonsville, Md.</b>			

10

10 OCT 1964 10:15 AM

MEMORANDUM

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

DATE: 10-10-64

RE: [Illegible]

1. [Illegible]

(10)

ADMINISTRATIVE

NEW YORK

10-10-64

10-10-64

10-10-64

[Illegible signature]

10-10-64

10-10-64

10-10-64

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11134		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11134	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Green, Lonie M</i>		2. DATE AND HOUR OF DEATH <i>10-27-65-12:00</i> p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Fredrick</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Thurmont</i> D. STREET ADDRESS (If rural, give location) <i>Rt. #2</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>7-26-92</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Mary land</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>James Linton</i>			
14. MOTHER'S MAIDEN NAME <i>Amanda Lewis</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Grover B. Green</i> ADDRESS <i>Graceham, Md.</i>			
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>Arteriosclerotic Vascular</i> DUE TO <i>Disease</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 days</i> <i>?</i>	
19A. DATE OF OPERATION <i>NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>N</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <i>(Month) (Day) (Year) (Hour)</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 22</i> 19 <i>65</i> to <i>Oct 27</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Oct 27</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert Allan Ratcheson</i> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Oct. 27, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert Allan Ratcheson</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-30-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Blue Ridge Cemetery</i>	
24D. LOCATION <i>Thurmont</i>		24E. LOCATION (City, town, or county) (State) <i>Fred. Co. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 1 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Raymond E. Greager</i> ADDRESS <i>Thurmont, Md.</i>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11135		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11135	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Bertha Gray (Allen)</i>		2. DATE AND HOUR OF DEATH <i>10/28/1965 12:15 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>938 W. Mulberry St.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>B. COUNTY</i> <i>938 W. Mulberry St.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore Maryland</i> D. STREET ADDRESS (If rural, give location) <i>18-01</i>			
5. SEX <i>F</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Divorced</i>	8. DATE OF BIRTH <i>4/1/1886</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Howard County Md. - U.S.A.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Earl Allen - 3706 Flower Rd.</i>			
18. <i>7-20-1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hypertension</i>		CAUSE OF DEATH (A) <i>Acute myocardial infarct</i> DUE TO (B) <i>Coronary Heart Disease</i> DUE TO (C) <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/20/64</i> 19 to <i>10/28/65</i> 19, that (I) (we) last saw the deceased alive on <i>10/28/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>J.R. Washington M.D.</i>		23B. DATE SIGNED <i>10/29/65</i>		23C. PHYSICIAN'S NAME (Type) <i>J.R. Washington</i>	
23D. ADDRESS <i>4006 Edmondson Ave</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>11/1/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mr. Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baldy Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 1 1965</i>		25B. NAME OF REGISTRAR <i>G. B. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John P. Carroll</i>	
25D. ADDRESS <i>1712 W. North Ave.</i>					

From my mother to my son

Dear son, I am writing to you

because I want to tell you

about my life and how I

feel about the world.

I hope you will find it

interesting and useful.

I am your mother, Mary

and I am writing to you

because I want to tell you

about my life and how I

feel about the world.

I hope you will find it

interesting and useful.

I am your mother, Mary

and I am writing to you

because I want to tell you

about my life and how I

feel about the world.

I hope you will find it

interesting and useful.

I am your mother, Mary

and I am writing to you

because I want to tell you

about my life and how I

feel about the world.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11136		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11136	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>William Jackson</u>			2. DATE AND HOUR OF DEATH <u>October 28, 1965</u> <u>5:40 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1335 Ward Street Baltimore, Maryland 21230</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-15-1892</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Andrew</u>		
14. MOTHER'S MAIDEN NAME <u>Georgiana</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		
16. SOCIAL SECURITY NO. <u>717-09-0125</u>			17. INFORMANT <u>Rev. Samuel B. Redd - 3611 Grantley Rd.</u>		
18. <u>443X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <u>Thrombosis of internal carotid artery &amp; massive brain infarction</u> (B) DUE TO <u>Chronic pyelonephritis &amp; obstructed by prostate</u> (C) <u>Hypertensive arteriosclerosis cardiovascular disease</u>		
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Congestive heart failure; kidney failure</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/21/65</u> <u>1965</u> to <u>10/28/65</u> <u>1965</u> , that (I) (we) lost saw the deceased alive on <u>October 28, 1965</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert R. Holthaus</u> M.D.			23B. DATE SIGNED <u>10/29/65</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert R. Holthaus, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>11-2-65</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1965</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fickens</u>			25C. FUNERAL DIRECTOR <u>Charles R. Law</u>		
25D. ADDRESS <u>802 Madison Ave.</u>					



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Nov 1 1965

65 11137

BALTIMORE CITY HEALTH DEPARTMENT

65 11137

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DONALD WEEMS

2. DATE AND HOUR PRONOUNCED DEAD

10/27/65 7:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2117 Barclay St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Childo

8. DATE OF BIRTH

6/6/50

9. AGE (In years  
last birthday)

15

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during last working life)

SCHOOL

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

CEPHUS WEEMS

14. MOTHER'S MAIDEN NAME

LAURETTA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MR CEPHUS WEEMS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Stab wound of chest

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

1800 Blk. Harlem Ave.

21D. TIME  
OF INJURY (APPROX.)(Month) (Day) (Year) (Hour)  
10 27 65 6:40p

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/28/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11/2/65

23C. NAME OF CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

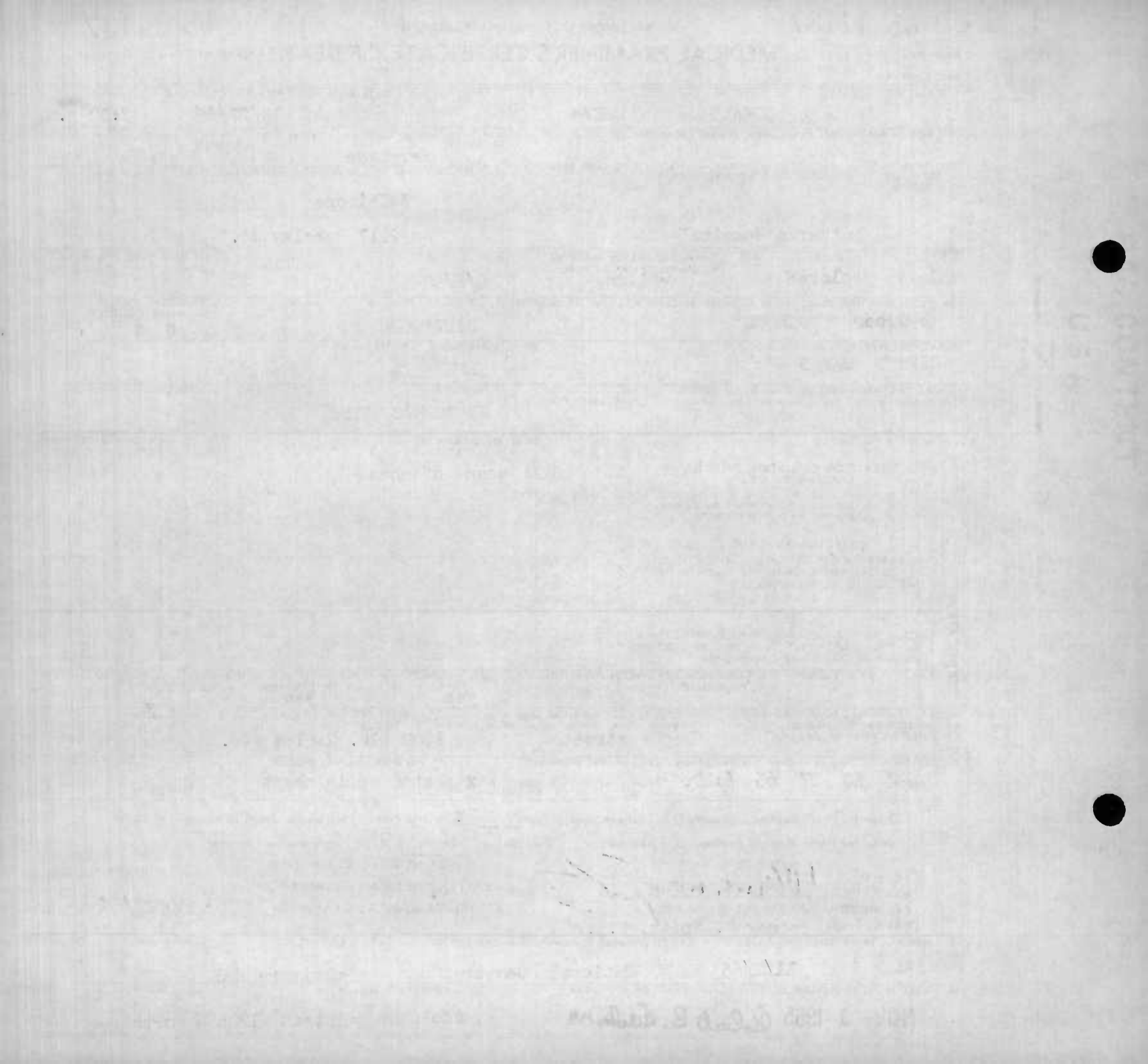
24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">65 11138</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">65 11138</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Margaret Hughes</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 28, 1965</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">803 Druid Hill Ave.</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">11-03</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">803 Druid Hill Ave.</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Separated</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10/10/17</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">48</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Domestic</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Virginia</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">JOSHUA REED</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">FLORENCE</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MISS MARY REED 803 Druid Hill Ave</span>	
18. <span style="font-size: 1.2em;">58101</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <span style="font-size: 1.5em;">Carbuncle of Liver</span> DUE TO (B) <span style="font-size: 1.5em;">Hypertensive C-V Disease</span> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10/27/65</span> 19 to <span style="font-size: 1.2em;">10/28/65</span> 19 that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10/27/65</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">W. Carner</span>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">10/28/65</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">W. CARNER</span>			23D. ADDRESS <span style="font-size: 1.2em;">1005 W. Lafayette Ave</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">10/4/65</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt Auburn Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">NOV 1 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">A. Halstead 1206 W. North Ave.</span>	



BIRTH NO. 65 11139		BALTIMORE CITY HEALTH DEPARTMENT		65 11139	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		HOSEA RHINEHART (RHINEHART, JR.)		10/28/65 12:00 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
713 Pierce St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 713 Pierce St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
male	colored	single	Dec. 19, 1901	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Seaman				Florida	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown ?			Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. ADDRESS		
			219-01-8329 Hospital Chart		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
443X1			(A) Arteriosclerotic and hypertensive cardio-vascular disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner					
CHIEF MEDICAL EXAMINER					
DATE SIGNED					
ACTUAL SIGNATURE		Werner U. Spitz, M.D.		10/28/65	
EXAMINER'S NAME (Type)				ASSOCIATE MEDICAL EXAMINER	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		11/3/65		Mt Auburn Cemetery	
				Baltimore Md	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
NOV 1 1965		Robert E. Fairbank		Adolphus Halstead 1206 W North Ave	

WALLER & CO. LTD.

MANUFACTURERS

STATION

Waller & Co. Ltd.

NOV 1 1955



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 11140					CERTIFICATE OF DEATH			Registered No. 65-26480-04	
1. NAME OF DECEASED (Type or Print) <b>WILLIE DAVID (DAVIS)</b>					2. DATE AND HOUR OF DEATH <b>10-28-65 1:35 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. HOSPITAL BALTO. MD.</b>					A. STATE <b>MD.</b> B. COUNTY <b>17-03</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>				
					D. STREET ADDRESS (If rural, give location) <b>713 PIERCE ST.</b>				
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SEPARATED</b>		8. DATE OF BIRTH <b>4-20-13</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DAY WORK</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CARO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>WILLIAM DAVID</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE BROWN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>213-14-0670</b>		17. INFORMANT <b>HOSPITAL CHART</b>			
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>CARCINOMATOSIS -</b> DUE TO (B) DUE TO (C) <b>CARCINOMA OF THE ESOPHAGUS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-3-65</b> <b>→ 10-28-65</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>09-10-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LAPAROTOMY &amp; GASTROSTOMY</b>			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>10-1-1965</b> to <b>10-28-1965</b> , that (I) <del>was</del> last saw the deceased alive on <b>10-28-1965</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.									
23A. SIGNATURE <b>Gary Lee Nobel</b>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-28-65</b>	
25C. PHYSICIAN'S NAME (Type) <b>GARY LEE NOBEL</b>				23D. ADDRESS <b>6851-C STURBRIDGE BALTO MD</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/31/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Laurinburg</b>		24D. LOCATION (City, town, or county) (State) <b>North Carolina</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Faby...</b>			25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>				



65 11141

BALTIMORE CITY HEALTH DEPARTMENT

65 11141

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LEROY CAMPBELL

2. DATE AND HOUR PRONOUNCED DEAD

10/26/65

8:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

13-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2030 Linden Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Separated

8. DATE OF BIRTH

2/14/

9. AGE (In years  
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

S Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

MOSES DAVIS

14. MOTHER'S MAIDEN NAME

EMMA PEDRO

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

219-38-4853

17. INFORMANT

ADDRESS

Mrs Emma Pedro, Loray S C

18. 581.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner H. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/26/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

10/30/65

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

ADOLPHUS HALSTEAD 1206 W North A

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

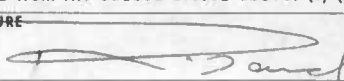
ADDRESS

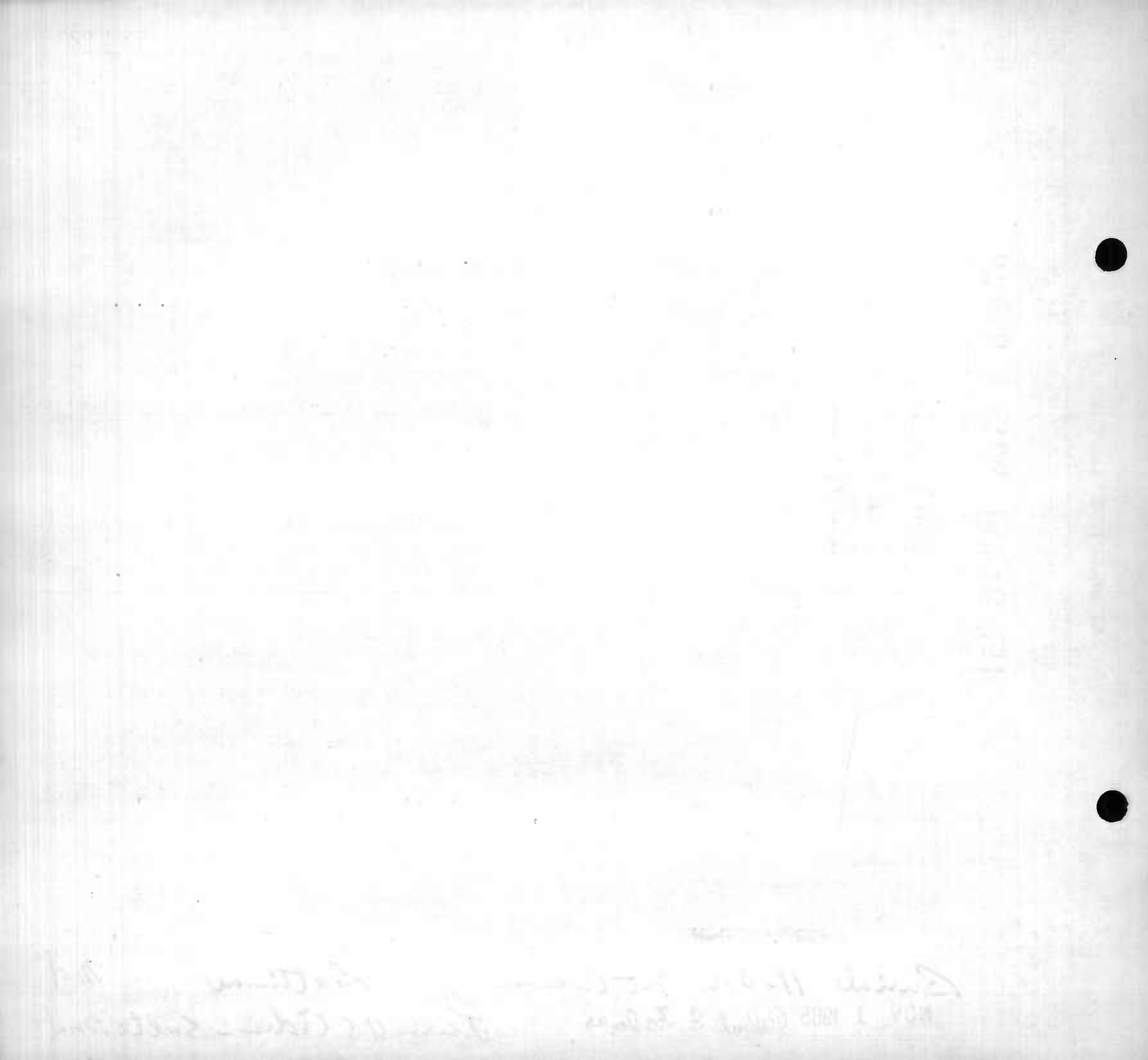
Adolphus Halstead



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
65 11142		CERTIFICATE OF DEATH		65 11142	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				(Type or Print)	
		Costello, Louis		2. DATE AND HOUR OF DEATH	
				October 30, 1965 4:45 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217				A. STATE Maryland	
				B. COUNTY 13-03	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 1561 Richland Street	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH Jan. 14, 1909	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Junius Costello	
14. MOTHER'S MAIDEN NAME Florence ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) none	
16. SOCIAL SECURITY NO. none				17. INFORMANT Melvin Costello-brother	
				ADDRESS 518 Baker Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH	
18. 15-5701x-002.1 Bleeding Esophageal varices. Laennec cirrhosis of the liver with Hepatoma					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. active pulmonary tuberculosis					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 17, 1965 to October 30, 1965, that (I) (we) last saw the deceased alive on October 30, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED October 30, 1965	
23C. PHYSICIAN'S NAME (Type) ANDRE, RIGAUD				23D. ADDRESS M.D. 1514 Division Street-Baltimore 17, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-3-65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) Md		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965	
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Burnell S. Oden		ADDRESS Baltimore, Md	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11143				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11143	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HELENA QUEEN</b>				2. DATE AND HOUR OF DEATH <b>2:45 10/29/65 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>15-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hosp.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>1303 Prestman St 21217</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>3-17-1907</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nursing (Ret.)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Sullivan</b>				14. MOTHER'S MAIDEN NAME <b>Celestine Chase</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lerturde Grayson - 2418 Arundel Ave</b>		ADDRESS	
18. <b>433.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Old L CVA</b>				CAUSE OF DEATH (A) DUE TO <b>DIALYSIS TOXICITY</b> (B) DUE TO <b>ARCHAETAMIA (presumed)</b> (C) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>11:30 AM 10/19/65</b> to <b>2:45 AM 10/29/65</b> , that (1) (we) last saw the deceased alive on <b>~ 2:00 AM 10/29/65</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.							
23A. SIGNATURE <b>Bruce A. Brian</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/29/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Bruce A. BRIAN</b> M.D.				23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-2-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Turnell &amp; Odum - Balto. Md</b>		ADDRESS	



16-11-11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 11144					CERTIFICATE OF DEATH					Registered No. 65 11144									
1. NAME OF DECEASED (Type or Print) <u>Elsa M. AMRHINE</u>										2. DATE AND HOUR OF DEATH <u>October 30</u>   <u>5:10</u> <u>A.M.</u>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u> D. STREET ADDRESS (If rural, give location) <u>2617 Taylor Avenue</u>									
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>8/15/1887</u>		9. AGE (In years last birthday) <u>78</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>McDaniel</u>										14. MOTHER'S MAIDEN NAME <u>Addie Henderson</u>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Jerry Lunak 3842 Elmora Ave. 21213</u>												
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>705751</u> <u>Brifluent Bronchopneumonia</u>										CAUSE OF DEATH (A) DUE TO <u>spontaneous</u> (B) DUE TO <u>degenerative</u> (C) <u>pruritus</u>					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <u>2</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>Yes</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <u>10/22/65</u> 19 <u>65</u> to <u>10/30</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>10/30</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <u>Donald H. Hall MD</u>										M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>10/30/65</u>				
23C. PHYSICIAN'S NAME (Type) <u>DR DONALD H HALL</u>										23D. ADDRESS M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>11/2/65</u>					24C. NAME of CEMETERY or CREMATORY <u>Immanuel Cemetery</u>					24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Farley</u>					25C. FUNERAL DIRECTOR <u>Henry Sander &amp; Sons Inc.</u>					ADDRESS <u>Baltimore Maryland 21213</u>				



1

65 11145

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11145

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LOUIS. A. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD 10/25/65 9:40 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 27-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2323 Montebello Terrace

5. SEX male 6. RACE colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married

8. DATE OF BIRTH 12-1-1888 9. AGE (In years lost birthday) 77

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician 10B. KIND OF BUSINESS OR INDUSTRY M.D.

11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Robert Johnson 14. MOTHER'S MAIDEN NAME Susan Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes W-W-1-5-6-1956 16. SOCIAL SECURITY NO.

17. INFORMANT Ruth L. Johnson ADDRESS 2323 Montebello Terrace

18. CAUSE OF DEATH

I E 981X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Gunshot wound of the chest involving the aorta, the heart and the right lung

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) in front of 2119 Guilford Ave.

21D. TIME OF INJURY (APPROX.) 10 25 65 9:25 p. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? shot while sitting in car

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) Werner U. Spitz M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 10/26/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 10-29-65 23C. NAME OF CEMETERY or CREMATORY Balto National Cem 23D. LOCATION (City, town, or county) (State) Balto Md

24A. DATE REC'D BY HEALTH DEPT. NOV 1 1965 24B. NAME OF REGISTRAR Robert E. Farber, M.D. 24C. FUNERAL DIRECTOR Rayer Sanders 2176 Preston St

24D. ADDRESS

Pharmacist  
Robert Johnson  
M.D.  
Married  
Apr 1891-2-6-1916

10-1-1888  
Maryland  
Sugar Island  
Robert Johnson 2232 1/2 1/2

Married 10-27-12  
Robert Johnson & Mary  
M.D.

65 11146

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11146

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MOSES JEFFERSON

2. DATE AND HOUR PRONOUNCED DEAD

October 28, 1965 10:43 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

909 E Madison St.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10-28-1928

9. AGE (In years  
last birthday)

37

10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

11. BIRTHPLACE (State or foreign country)

East Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Eugene Jefferson

14. MOTHER'S MAIDEN NAME

Jonnie Glenn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Earlaine Dilworth

18. 581.01

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Confluent bronchopneumonia and right empyema

DUE TO Fatty metamorphosis of liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Oct. 29, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-2-65

23C. NAME OF CEMETERY or CREMATORY

Balto National Cem Balto

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

24B. NAME OF REGISTRAR

Robert E. Feltz

24C. FUNERAL DIRECTOR

Rayner Sanders 2176 E Preston St

ADDRESS

Printed

Nov 1 1899



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11147				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11147	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JESSE E WILLIE LITTLE</b>				2. DATE AND HOUR OF DEATH <b>10-27-65 12:05PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL, WILKENS &amp; CATON AVE BALTO MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>20-07</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>139 SO MONASTERY AVE #29</b>			
5. SEX <b>MALE</b>	6. RACE <b>W COLORED</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SEPARATED</b>	8. DATE OF BIRTH <b>4-7-06</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>ALABAMA</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>X8418017944</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL CLINIC RECORDS</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTHERIOSCLEROSIS</b>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-6 1963</b> to <b>10-27 1965</b> , that (X) (we) last saw the deceased alive on <b>10-27 1965</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Manfred Amrhein</i> M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>10-27-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>MANFRED AMRHEIN</b>		23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL -CATON &amp; WILKENS AVE</b>					
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/1/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Aslington Phillips</b>		ADDRESS <b>1727 N. Mount...</b>	

31-10-1971

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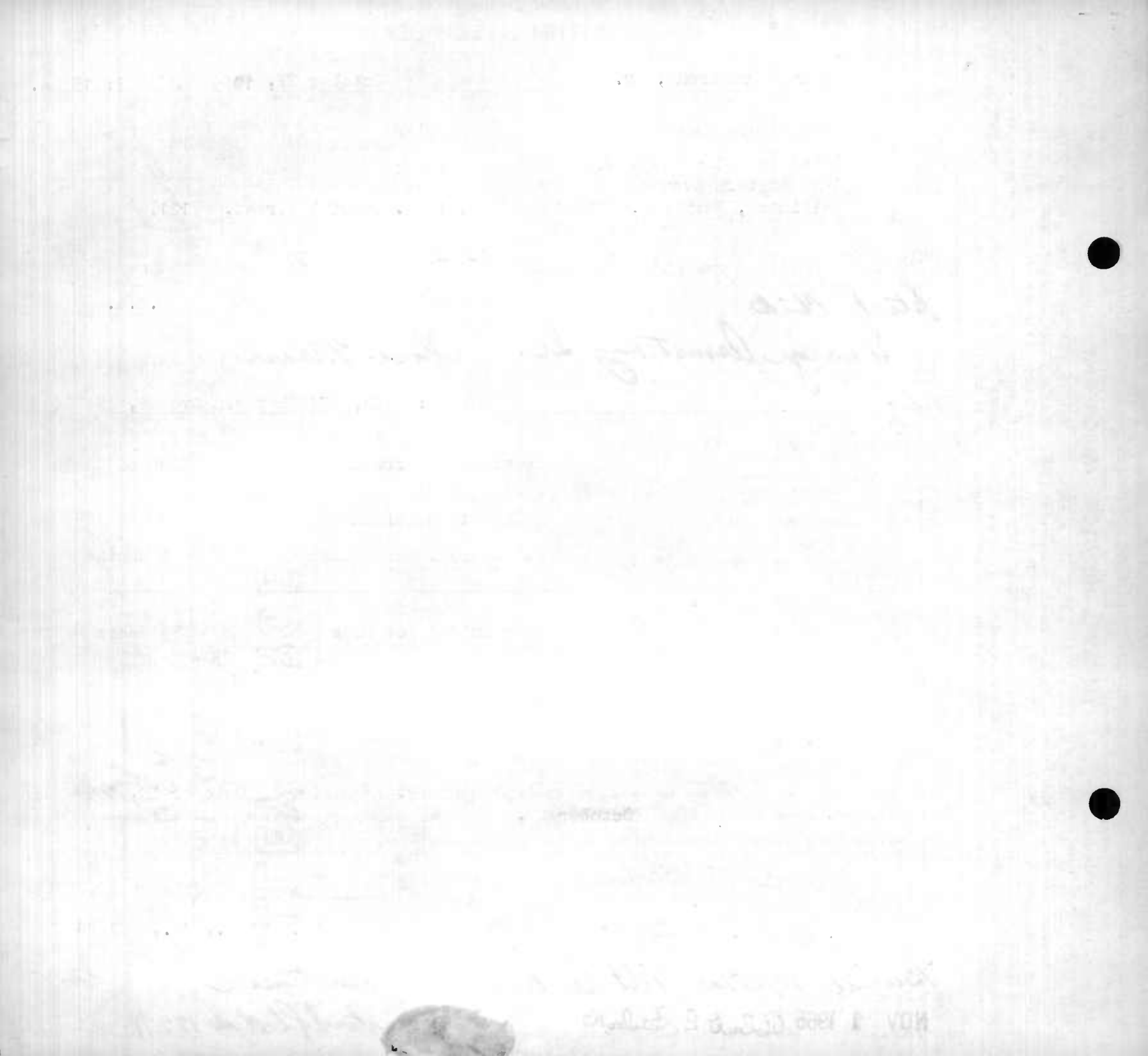
1750

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## FUNERAL DIRECTOR: IMPORTANT

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
George Armstrong, Jr.		October 23, 1965 1: 15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224		Maryland Baltimore	
5. SEX		6. RACE	
Male	Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
		Single	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Stack Clerk			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Armstrong Sr.		Class Moore	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No.			
17. INFORMANT		ADDRESS	
RECORDS: BCH, 4940 Eastern Avenue, #21224			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Time of Death	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20 Minutes	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		25 Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from September 29, 1965 to October 23, 1965, that (I) (we) last saw the deceased alive on October 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23A. SIGNATURE		23B. DATE SIGNED	
James T. Sparks		October 23, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
DR. JAMES T. SPARKS		4940 Eastern Avenue, Balto., Md., #21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		10/28/65	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Mt. Auburn		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
NOV 1 1965		Robert E. Fairbank	
25C. FUNERAL DIRECTOR		ADDRESS	
Richard S. Phillips		1727 M. Monroe	



65 11149		BALTIMORE CITY HEALTH DEPARTMENT		65 11149	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		CHARLES W LYNCH		2. DATE AND HOUR PRONOUNCED DEAD 10/27/65 10:10 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
31 City Hospitals		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4331 E. Lombard St.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH June 3, 1911	9. AGE (In years last birthday) 54	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph W Lynch			
14. MOTHER'S MAIDEN NAME Mary Gillen		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-18-1295		17. INFORMANT Mrs Gertrude Genco 121 N Potomac St			
18. CAUSE OF DEATH Pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 11/2/65		23C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem	
23D. LOCATION Baltimore Md		24A. DATE REC'D BY HEALTH DEPT. NOV 1 1965			
24B. NAME OF REGISTRAR Robert E. Farkas		24C. FUNERAL DIRECTOR J. Melville Jenkins 2713 Kirk Ave.			
24D. ADDRESS					

VALLEY FORT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 11150					REGISTERED NO. 65 11150					
M.E. CASE NO.					CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>WHITLEY, Robert J.</b>					2. DATE AND HOUR OF DEATH <b>October 28, 1965 7:20 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St Joseph's Hospital</b>					4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Avenue</b> D. STREET ADDRESS (If rural, give location) <b>2630 Beryl Avenue</b>					
5. SEX <b>Male</b>	6. RACE <b>colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widower Separated</b>	8. DATE OF BIRTH <b>5/25/07</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Sparrows Pt. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Whitley</b>			14. MOTHER'S MAIDEN NAME <b>Annie Jones</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>213-09-0251</b>			17. INFORMANT <b>Catherine Watson</b>			ADDRESS <b>2630 Beryl Ave.</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>422.11</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO <b>arteriosclerotic cardiovascular disease</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(B) DUE TO					
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>October 24</b> 19 <b>65</b> to <b>October 28</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>October 28</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Bernardino Alonso</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>10-28-65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Bernardino Alonso</b>					23D. ADDRESS M.O. <b>1400 N. Caroline Street</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-1-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>			25C. FUNERAL DIRECTOR <b>Randolph J. Collick</b>				
						ADDRESS <b>1412 E. Preston St.</b>				



arteriosclerotic cardiovascular  
disease

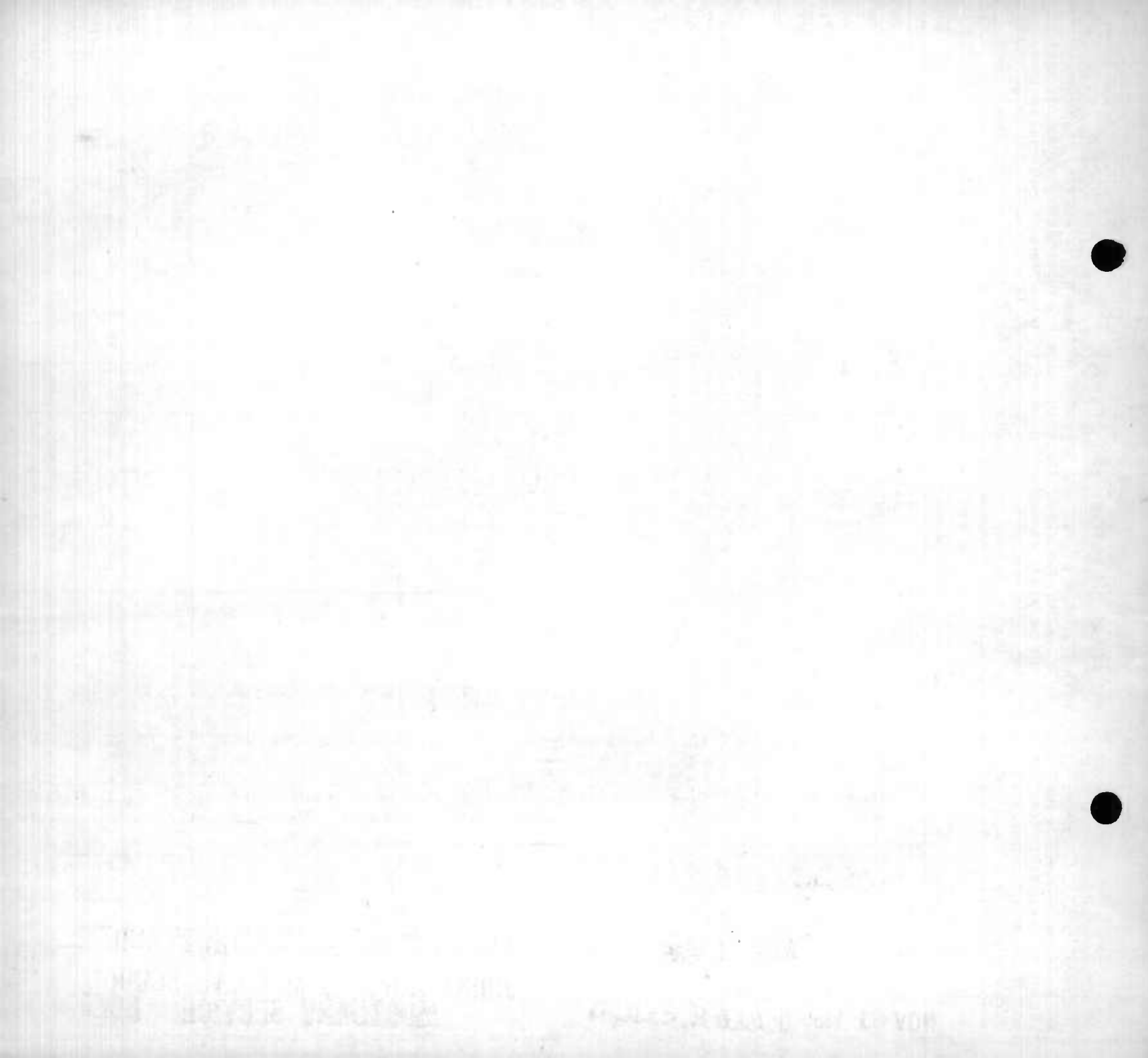
pulmonary thrombosis

no

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-26180 65 11151		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11151	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) IVEY BABY GIRL		2. DATE AND HOUR OF DEATH Oct. 13 1965 12:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 425 INVAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15 27-16 D. STREET ADDRESS (If rural, give location) 2728 VIRGINIA AVE			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never	8. DATE OF BIRTH 10/13/65	9. AGE (In years last birthday) 1	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 1 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME IVEY, LENWOOD		14. MOTHER'S MAIDEN NAME BULLOCK, JEDA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT father ADDRESS same	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Prematurity DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hr 54 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/13/65 to 10/13/65, that (I) (we) lost saw the deceased alive on 10/13/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Barbara C. Wagner M.D.		23B. DATE SIGNED 10/13/65		23C. PHYSICIAN'S NAME (Type) BARBARA C. WAGNER	
24A. BURIAL CREMATION, 24B. TIME OF REMOVAL (Specify)		24C. NAME OF CEMETERY or CREMATOR NOV 1 1965		24D. LOCATION (City, town, or county) (State) ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BOLD	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11152		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11152	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Steininger, Baby Girl</i>		2. DATE AND HOUR OF DEATH <i>10-25-65 17 30 a.m.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital of Baltimore</i>		A. STATE <i>MD</i> 8. COUNTY <i>MARYLAND</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>27-17</i>			
		D. STREET ADDRESS (If rural, give location) <i>5009 Sunset Rd. # 15</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i>	8. DATE OF BIRTH <i>10/23/65</i>	9. AGE (In years last birthday) <i>40</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Sinai Hospital</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>JOSEPH Steininger</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Lustman</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart</i>	
18. <i>75-0 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Anaphylactic Shock</i> DUE TO  (B) DUE TO  (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>40 hrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>th</i> (this hospital) attended the deceased from <i>10-23-65</i> to <i>10-25-19 65</i> , that (I) (we) lost saw the deceased alive on <i>10-25</i> 19 <i>65</i> and that in (my), (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A H Mahsoob</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10-25-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>A. H. MAHSOOB</i>		23D. ADDRESS <i>Sinai Hosp. of Balt.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>NOV 1 1965</i>		24B. DATE		24C. NAME OF CEMETERY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 1 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkas</i>		25C. MORTUARY SERVICE - BCHO	

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# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>65-2628265</u> <u>11153</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 11153</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Stansbury, Baby Boy</u>		2. DATE AND HOUR OF DEATH <u>10-14-65</u> <u>9 05</u> <u>1 M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hosp. of Bacto., Inc.</u>		A. STATE <u>MD</u> B. COUNTY <u>Bacto.</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Pikesville</u>			
		D. STREET ADDRESS (If rural, give location) <u>125 Clarendon Ave</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>10-14-65</u>	9. AGE (In years last birthday) <u>1</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Carroll Stansbury</u>		14. MOTHER'S MAIDEN NAME <u>Linda Clark</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>773.51</u>		CAUSE OF DEATH (A) <u>Respiratory failure</u> DUE TO (B) <u>Prematurity - 625 gms</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 45 min.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>10/14/65</u> 19 <u>65</u> to <u>10/14/65</u> 19 <u>65</u> , that (we) last saw the deceased alive on <u>10/14/65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sidney Seidman</u>				23B. DATE SIGNED <u>10/14/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sidney Seidman</u>				23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. NAME OF CEMETERY or CREMATORY		24C. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>65 11154</b>		<b>CERTIFICATE OF DEATH</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11154</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Catherine Gunning</b>				2. DATE AND HOUR OF DEATH <b>October 29, 1965</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Hood Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4710 Dartford Ave</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7/10/1881</b>	9. AGE (In years lost birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bon Secours Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>? Coleman</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Thomas R. Gunning</b> ADDRESS <b>903 Fordwood Circle</b>			
18. <b>422.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</b> DUE TO (B) <b>GENERAL ARTERIO SCLEROSIS</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/1/65</b> to <b>10/29/65</b> , that (I) (we) last saw the deceased alive on <b>10/29/65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John H. Shaw</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>John H Shaw</b>				23D. ADDRESS <b>5800 Edmondson Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/2/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Dickner &amp; Sons</b>			



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 05 11155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 05 11155

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES F. CARBAUGH

2. DATE AND HOUR PRONOUNCED DEAD

10/30/65 2:00 a.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2124 Christian Street

23

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Sept. 4, 1897

AGE in years  
68If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bricklayer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Adam C. Carbaugh

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.  
217-07-4496

17. INFORMANT

Mrs. Eleanor Colgan 315 Old Riverside Road  
Brooklyn Park, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/30/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/21/1965

23C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Woodlawn, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Fickner &amp; Son, Baltimore, Md.

ADDRESS

VALLEY BOULE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>D-525 65 11156</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 11156</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mary Elizabeth Duncan</u>		2. DATE AND HOUR OF DEATH <u>October 29, 1965</u> <u>6:47</u> A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4940 Eastern Avenue 21224</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>2-7-1886</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Louisville, Kentucky</u> <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Robert Duncan</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Mulloy</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>			
16. SOCIAL SECURITY NO. <u>213-14-3328</u>		17. INFORMANT <u>RECORDS: BCH 4940 Eastern Avenue 21224</u>			
18. <u>35-1X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> DUE TO <u>Spastic Paraplegia</u> DUE TO <u>Arteriosclerotic Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>Years</u> <u>Years</u>			
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 28, 19 58</u> to <u>October 29, 19 65</u> , that (I) (we) last saw the deceased alive on <u>October 29, 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Laurice McAfee</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>October 29, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Laurice McAfee</u>		23D. ADDRESS M.D. <u>4940 Eastern Avenue Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/30/1965</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fairley</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Fisher &amp; Son</u>			
25D. ADDRESS <u>Baltimore, Md. 17 North &amp; Pa. Ave.</u>					





65 11157		BALTIMORE CITY HEALTH DEPARTMENT		65 11157	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		FRANK McHUGH		2. DATE AND HOUR PRONOUNCED DEAD 10/30/65 11:07 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
42 Sinai Hospital		D. STREET ADDRESS (If rural, give location) 3433 University Place			
5. SEX male	6. RACE white	7. <del>MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</del> Single	8. DATE OF BIRTH 11-8, 1917	9. AGE (In years last birthday) 47	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Lynn Mass.	
13. FATHER'S NAME Frank J. McHugh Sr.		14. MOTHER'S MAIDEN NAME Cathleen Bresnahan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. E8224 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries DUE TO INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Security Blvd. and Belmar Rd. 03-00	
21D. TIME OF INJURY (APPROX.) 10 30 65 10:30 p.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? driver of auto which struck embankment	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/31/65	
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE 10/31/65		23C. NAME of CEMETERY or CREMATORY St. Joseph	
24A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR Wm. J. Jackson	
		24D. LOCATION (City, town, or county) Lynn Mass		ADDRESS Mta Ball's, Md	



VALLEY FORT

# FUNERAL DIRECTOR: IMPORTANT

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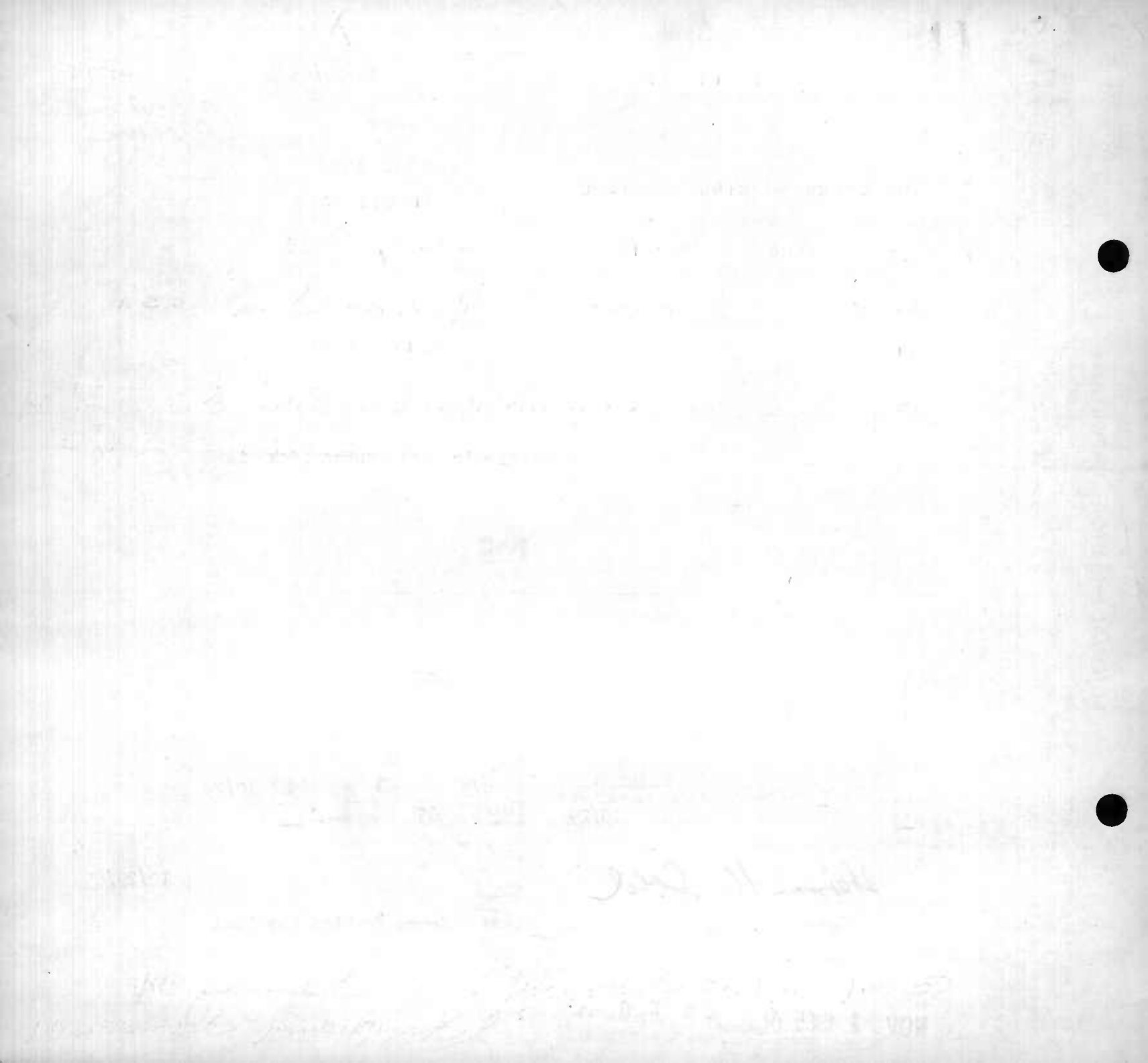
BIRTH NO. 65 11158				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11158	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Dora Lee Carlton</b>				2. DATE AND HOUR OF DEATH <b>October 30, 1965</b>   <b>11:10 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Hillcrest Nursing Home</b> <b>212 Stoney Run Lane</b> <b>Baltimore, Maryland 21210</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>107 Enfield Road</b>   <b>12</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 29, 1871</b>	9. AGE (In years last birthday) <b>94</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Widowed</b>		11. BIRTHPLACE (State or foreign country) <b>Owenton, Kentucky</b>	
13. FATHER'S NAME <b>Walter L. Lancaster</b>				14. MOTHER'S MAIDEN NAME <b>Effie Jane Willhoit</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>302-01-9807</b>		17. INFORMANT <b>Mr. James C. McGohan</b>   <b>107 Enfield Rd. Baltimore, Md. 12</b>	
18. <b>422.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardio-vascular disease</b>				CAUSE OF DEATH (A) <b>Arteriosclerotic cardio-vascular disease</b> (B) <b>Due to</b> (C) <b>Due to</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>October 19 55</b> to <b>October 30, 19 65</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>October 29, 19 65</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <i>Lloyd E. Saylor</i> <b>Lloyd E. Saylor</b>				M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Nov. 1, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lloyd E. Saylor</b>				23D. ADDRESS <b>3902 Greenmount Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>11/2/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Forest Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Erlanger, Kentucky</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. F. Jackson &amp; Sons</i>   <b>Balto. Md. 17</b>			



# FUNERAL DIRECTOR: IMPORTANT

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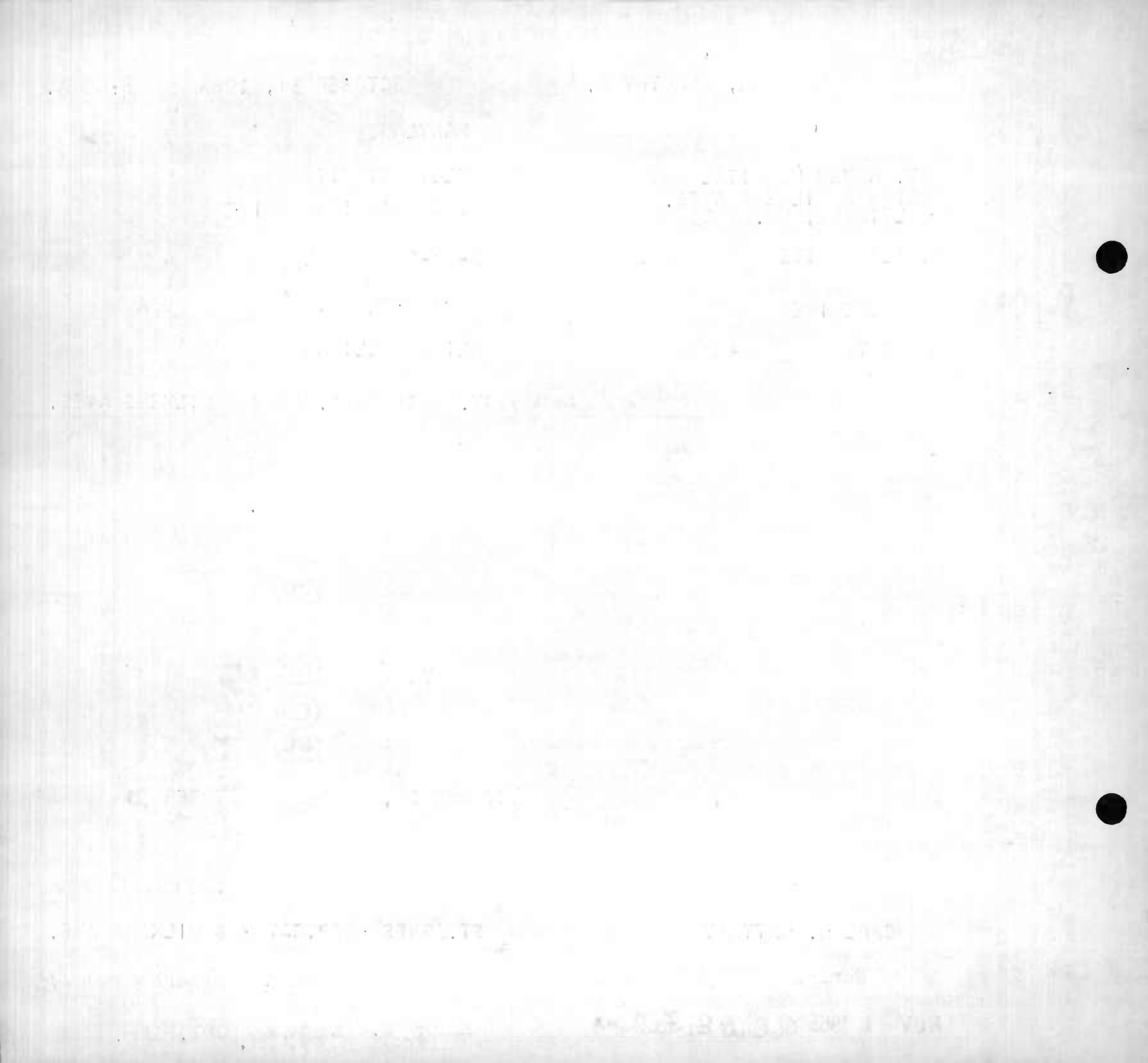
BIRTH NO. <span style="font-size: 2em;">65 11159</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 2em;">65 11159</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>IRVIN PATE</b>		<b>10/29/65</b> <span style="float: right;"><b>4:00 P</b></span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b> B. COUNTY <span style="float: right;"><i>Caroline</i></span>			
<b>33 THE JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>FEDERALSBURG</b> <span style="float: right;"><i>55-00</i></span>			
		D. STREET ADDRESS (If rural, give location) <b>3 BRIDGES ROAD</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8-15-02</b>	9. AGE (In years lost birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Mc Kersy, Tenn</i>	
13. FATHER'S NAME <b>OTIS</b>		14. MOTHER'S MAIDEN NAME <b>MUNSIE NOLEM</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-16-4702</i>		17. INFORMANT ADDRESS <i>Mrs. Lucy Pate - Federalsburg, Md.</i>	
18. <i>204.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic myelogenous leukemia</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/8</i> <i>19 65</i> to <i>10/29</i> <i>19 65</i> , that (I) (we) last saw the deceased alive on <i>10/29</i> <i>19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Herman K. Gold</i>				23B. DATE SIGNED <b>10/29/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Herman K. Gold</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>11/7/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Federal Hill Cemetery - Federalsburg, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Fisk</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Harry Williams - Federalsburg, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11160		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11160	
1. NAME OF DECEASED (Type or Print) <b>HOFFMAN, DOROTHY A.</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 31, 1965   8:00 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Howard</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVES. BALTIMORE, MD. # 29</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ELLICOTT CITY</b> D. STREET ADDRESS (If rural, give location) <b>1117 CARRIGAN DRIVE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3-14-20</b>	9. AGE (In years lost birthday) <b>45</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ROBERT DEAN</b>			14. MOTHER'S MAIDEN NAME <b>ALICE SULLIVAN</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>277-12-3509</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSP. CATON &amp; WILKENS AVES.</b>		
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Carcinoma breast &amp; Metastasis to Liver. Loss of blood due to Sanguineous esophageal varices.</b> (B) _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>16 Months</b>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 26, 1965</b> to <b>OCTOBER 31, 1965</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 31, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carl H. Matthey</b> M.D.						23B. DATE SIGNED <b>Oct. 31, 19</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARL H. MATTHEY</b> M.D.				23D. ADDRESS <b>ST. AGNES HOSP. CATON &amp; WILKENS AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>Burial 11/3/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Beulah Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Churchill, Allegheny Co. Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Harry H. Witzke, 321 Col. Pike, Ellicott City, Md.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11161	
BIRTH NO. 65 11161		CERTIFICATE OF DEATH		6 30 P.M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELIZABETH (BESSIE) RUBY		2. DATE AND HOUR OF DEATH 10-26-65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. STATE Md. 6. COUNTY 27-09	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 11-1-65		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.		D. STREET ADDRESS (If rural, give location) 1539 NORTHBOURNE RD.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Sept 29 1897	9. AGE (In years last birthday) 72 70	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTO., MD.	
13. FATHER'S NAME JAMES LOUGHRAN		14. MOTHER'S MAIDEN NAME ELIZABETH SMITH		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT HUSBAND MR. JOHN F. RUBY SR. ADDRESS (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Carcinoma of esophagus (B) DUE TO (C) Same		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II Metastases.		3 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 05/14/64		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal destruction	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/8 1964 to 10/26 1965, that (I) (we) last saw the deceased alive on 10/22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Samuel Morrison M.D.		23B. DATE SIGNED 10/26/65	
23C. PHYSICIAN'S NAME (Type) SAMUEL MORRISON		23D. ADDRESS M.D. 11 E Chase St Balto 2, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-30-65		24C. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PK	
24D. LOCATION (City, town, or county) (State) BALTO. MD		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR J. Walter Conklin		25D. ADDRESS 5444 BELAIR RD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11162		BALTIMORE CITY HEALTH DEPARTMENT		65 11162	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>MATILDA A. GESSNER</b>		2. DATE AND HOUR OF DEATH <b>10-26-65 12:33 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>7 Mercy</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>3409 CYNDALE AVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED-SEP.</b>	8. DATE OF BIRTH <b>9-12-1913</b>	9. AGE (In years lost birthday) <b>52</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>FALLSTON, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>WILSON F. RAHLL</b>		14. MOTHER'S MAIDEN NAME <b>CLARA M. LYNCH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>SON</b> ADDRESS <b>MR. HARRY L. GESSNER (SAME)</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Pulmonary Embolism</b> DUE TO (B) <b>Congestive Heart Failure</b> DUE TO (C) <b>Coronary Artery Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>agonal</b> <b>3 min</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>10/25</b> 19 <b>65</b> to <b>10/26</b> 19 <b>65</b> , that (I) ( <del>he</del> ) lost saw the deceased alive on <b>10/26</b> 19 <b>65</b> and that in ( <del>my</del> ) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>he</del> ) (did) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <b>Chester C. Collins Jr.</b> M.D.		23B. DATE SIGNED <b>10/26/65</b>		23C. PHYSICIAN'S NAME (Type) <b>Chester C. Collins Jr.</b> M.D.	
23D. ADDRESS <b>Mary Hox</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-29-65</b>	
24C. NAME OF CEMETERY or CREMATORY <b>GARDENS OF FAITH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>J. Walter Conklin</b>		25D. ADDRESS <b>5444 BELAIR RD</b>	

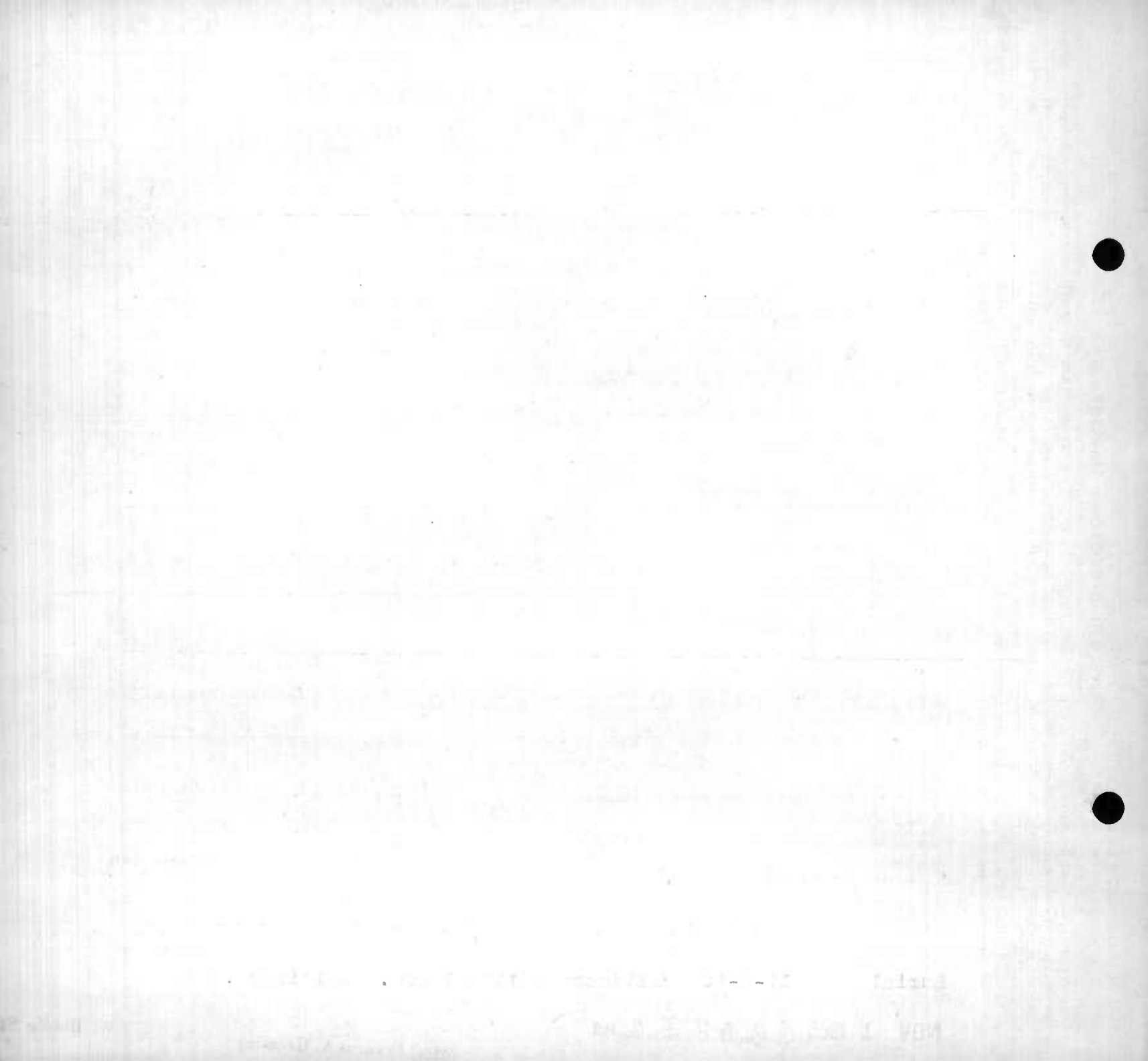
James Buchanan  
Agent for the  
American People

James Buchanan  
Agent for the  
American People

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11163				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11163	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Thomas Elroy Smith, Jr.</i>				2. DATE AND HOUR OF DEATH <i>10/28/65 8:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<i>808 W. LANVALE ST.</i>				<i>Maryland</i>		<i>1703</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location)			
				<i>808 W. LANVALE ST.</i>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Male</i>	<i>Negro</i>	<i>married</i>	<i>10/6/92</i>	<i>73</i>	<i>carpenter helper</i>	<i>Maryland</i>	<i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME		
<i>carpenter helper</i>			<i>Social Sec Adm</i>		<i>Thomas E.</i>		
13. FATHER'S NAME			14. MOTHER'S MARRIAGE NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
<i>Thomas E.</i>			<i>Julia Bolden</i>		<i>yes 1918-1919</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS		
<i>216 40-2466</i>			<i>WIFE</i>		<i>SAME</i>		
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				<i>Acute CORONARY Insufficiency 2 hours</i>			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				<i>ARTERIOsclerotic Heart Disease 4 yrs.</i>			
ANTECEDENT CAUSES				<i>CORONARY ARTERIOsclerosis unknown</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>0</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <i>9/14</i> 19 <i>63</i> to <i>10/28</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>10/27</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<i>Elijah Saunders</i>				<i>10/28/65</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<i>ELIJAH SAUNDERS</i>				<i>3414 DUVALL AVE. Baltimore, MD 21216</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>11-2-65</i>		<i>Baltimore National Cem.</i>		<i>Baltimore, Md</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<i>NOV 1 1965</i>		<i>Robert E. Farber</i>		<i>Mrs. Frances A. Hemaley</i>		<i>533 W. Biddle St.</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11164

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EDWIN KRAMMER

2. DATE AND HOUR PRONOUNCED DEAD

Oct. 29, 1965 10:28 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2014 Ramsay St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

January 10, 1905

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Brush Inspector

10B. KIND OF BUSINESS OR INDUSTRY

Brush Mfg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles H. KRAMMER

14. MOTHER'S MAIDEN NAME

Lilia BERGMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

Yes World War II

16. SOCIAL  
SECURITY NO.

21401-8632

17. INFORMANT

ALMA KRAMMER. 2014 Ramsay St.

ADDRESS

18. CAUSE OF DEATH

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-29-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-1-65

23C. NAME OF CEMETERY or CREMATORY

London Park

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Geo L. Schwab Funeral Home  
Francis D. Miller 2101 Ludwig Ave.

ADDRESS

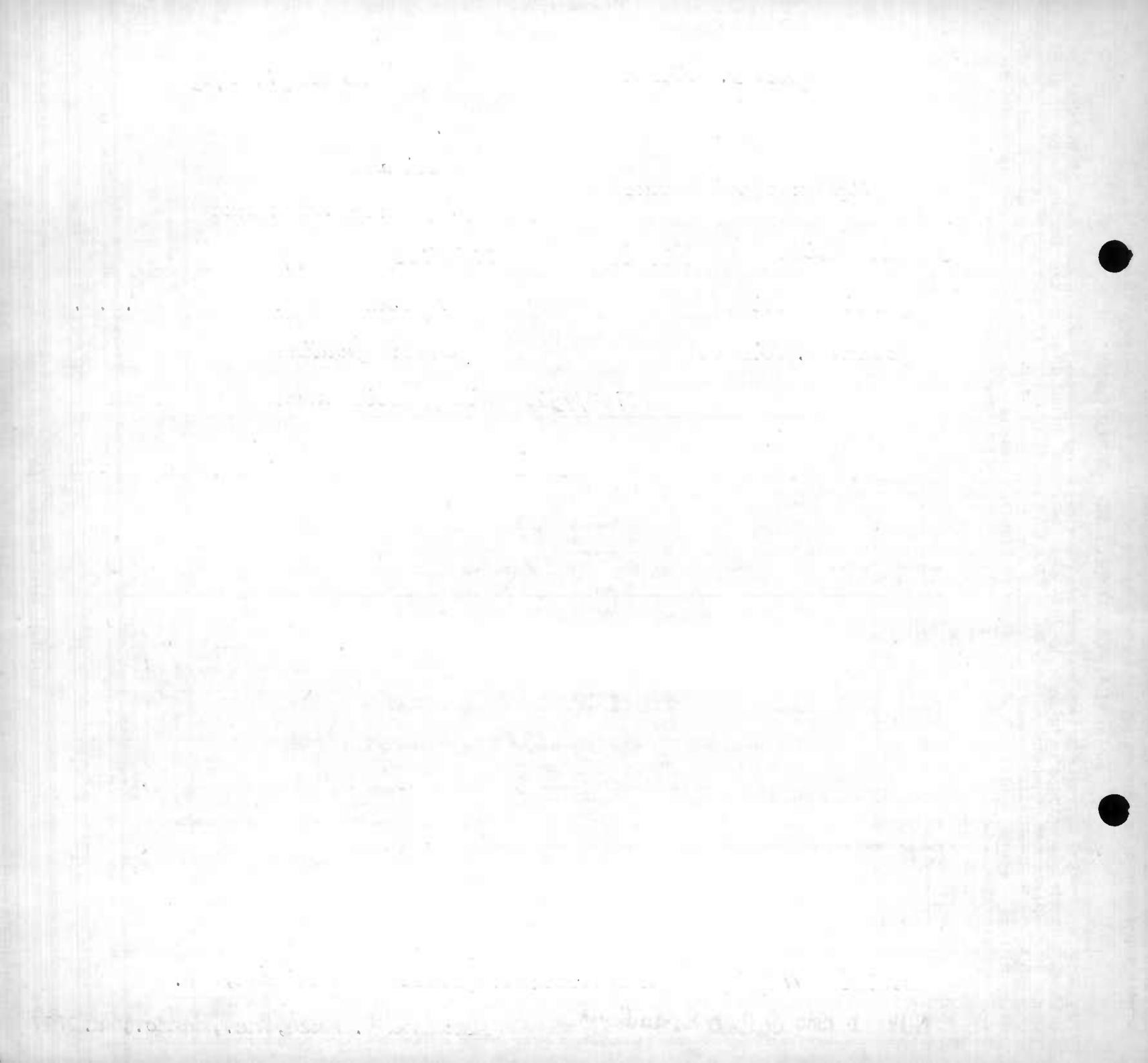




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <span style="font-size: 1.5em;">65 11165</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">65 11165</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Agnes J. Riesett</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 31, 1965</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">3105 Rueckert Avenue</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">2703</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>	
		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3105 Rueckert Avenue</span>			
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Single</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">11/6/1887</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">77</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Cashier Retired</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Joseph V. Riesett</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Johanna Gundina</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216077520</span>		17. INFORMANT <span style="font-size: 1.2em;">Miss Jennie Brown</span>	
				ADDRESS <span style="font-size: 1.2em;">Same</span>	
18. <span style="font-size: 1.2em;">420.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <span style="font-size: 1.2em;">acute myocardial infarction</span> DUE TO (B) DUE TO (C) <span style="font-size: 1.2em;">art scl cv disease</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1/2 hr?</span>          <span style="font-size: 1.2em;">15 yrs +</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O none</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.2em;">no</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Jan 19 63</span> to <span style="font-size: 1.2em;">10/31 19 65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10/31 19 65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Manner Feldman</span>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">11/3/65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">NOV 1 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fairbank</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck, Inc., Balto., Md.</span>	
				ADDRESS <span style="font-size: 1.2em;">21214</span>	



BIRTH NO.

65 11166

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 11166

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLOTTE J. SCHLUDERBERG

2. DATE AND HOUR PRONOUNCED DEAD

10/30/65 5:45 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2912 Glendale Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

2/16/1891

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles E. Osenburg

14. MOTHER'S MAIDEN NAME

Minnie Zastrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

-----

17. INFORMANT

Mrs. Phyllis Carter, 5700 St. Anthony  
New Orleans, La.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORK☐NOT WHILE  
AT WORK☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/31/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/3/65

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc., 5305 Harford Rd.  
Balto., Md. 21214

W/ALC 6-10-61 1046E

USA

6-10-61



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

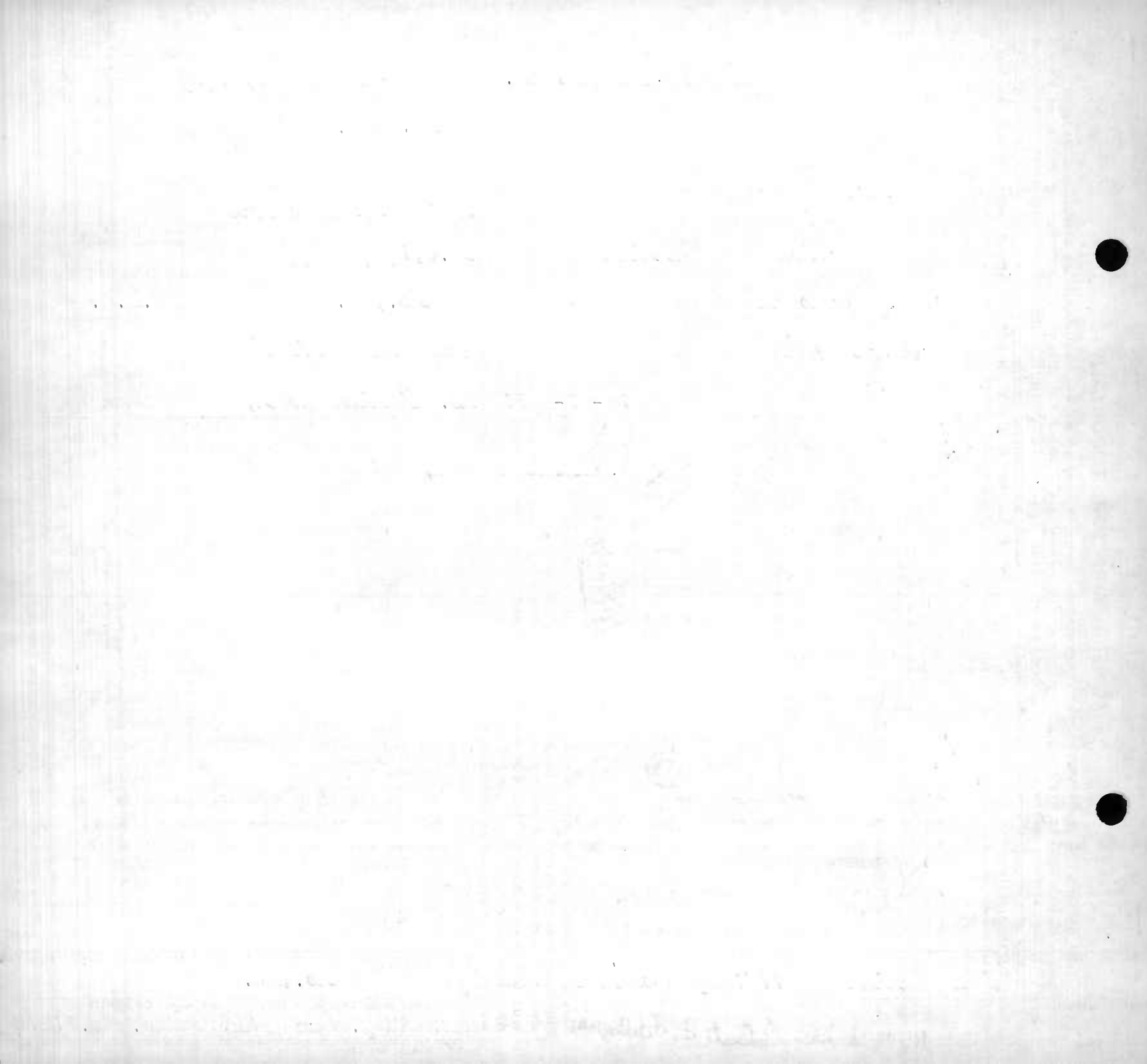
BIRTH NO.		65 11167		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11167	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>GODFREY R. HARRIS, SR</b>				2. DATE AND HOUR OF DEATH <b>30 - Oct 1965 3:22 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>21-44</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>3404 White Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>6-1-01</b>	9. AGE (In years lost birthday) <b>64</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John HARRIS</b>				14. MOTHER'S MAIDEN NAME <b>MARY Fox</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>2/2056 285</b>		17. INFORMANT <b>Hospital CHART</b>		ADDRESS	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>C.V.A.</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>7 - Oct 65</b> to <b>30 - Oct 1965</b> , that (2) (we) last saw the deceased alive on <b>30 - Oct 1965</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.							
23A. SIGNATURE <b>J. C. Cullis M.D.</b>						23B. DATE SIGNED <b>30 - Oct - 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. C. Cullis</b>		23D. ADDRESS <b>MARYLAND GENERAL HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/3/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Faulkner</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Rubk, Inc., Balto., Md.</b>		ADDRESS	





1-B-7601  
To be approved by Medical Examiner  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11168		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11168	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Melvin Joseph Baker, Sr.		2. DATE AND HOUR OF DEATH October 28, 1965 2:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5917 Belair Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balto., Md. B. COUNTY 27-85 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6002 Bertram Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 8, 1909	9. AGE (In years last birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alonzo Baker		14. MOTHER'S MAIDEN NAME Jeannette Mallieu	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 226-01-3511		17. INFORMANT Mrs. Lillian Baker, Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X I CORONARY heart disease DUE TO Diabetes Mellitus 3 years ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute peptic ulcer 1 mes		MEDICAL CERTIFICATION 10/28/65 CERTIFICATION APPROVED [Signature] 10/28/65 MEDICAL EXAMINER [Signature]		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1959 to Oct 28 1965, that (I) (we) last saw the deceased alive on Oct 25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.		23B. DATE SIGNED 10-28-65		23C. PHYSICIAN'S NAME (Type) RDonald Jandorf	
23D. ADDRESS M.D. 6077 Harford Rd		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11/1/65		24C. NAME of CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214	



65 11169

BALTIMORE CITY HEALTH DEPARTMENT

65 11169

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES A. HASSLINGER

2. DATE AND HOUR PRONOUNCED DEAD

10/29/65 7:43 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1823 E. 33 St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12/14/1885

9. AGE (In years  
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Restaurant Owner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Hasslinger

14. MOTHER'S MAIDEN NAME

Katie Kurchenberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. (If yes, give war or dates of service))16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. May Crockett, 1823 E. 33rd St.

18. 422.1 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic cardiovascular disease  
(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/30/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/2/65

23C. NAME of CEMETERY or CREMATORY

Oaklawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

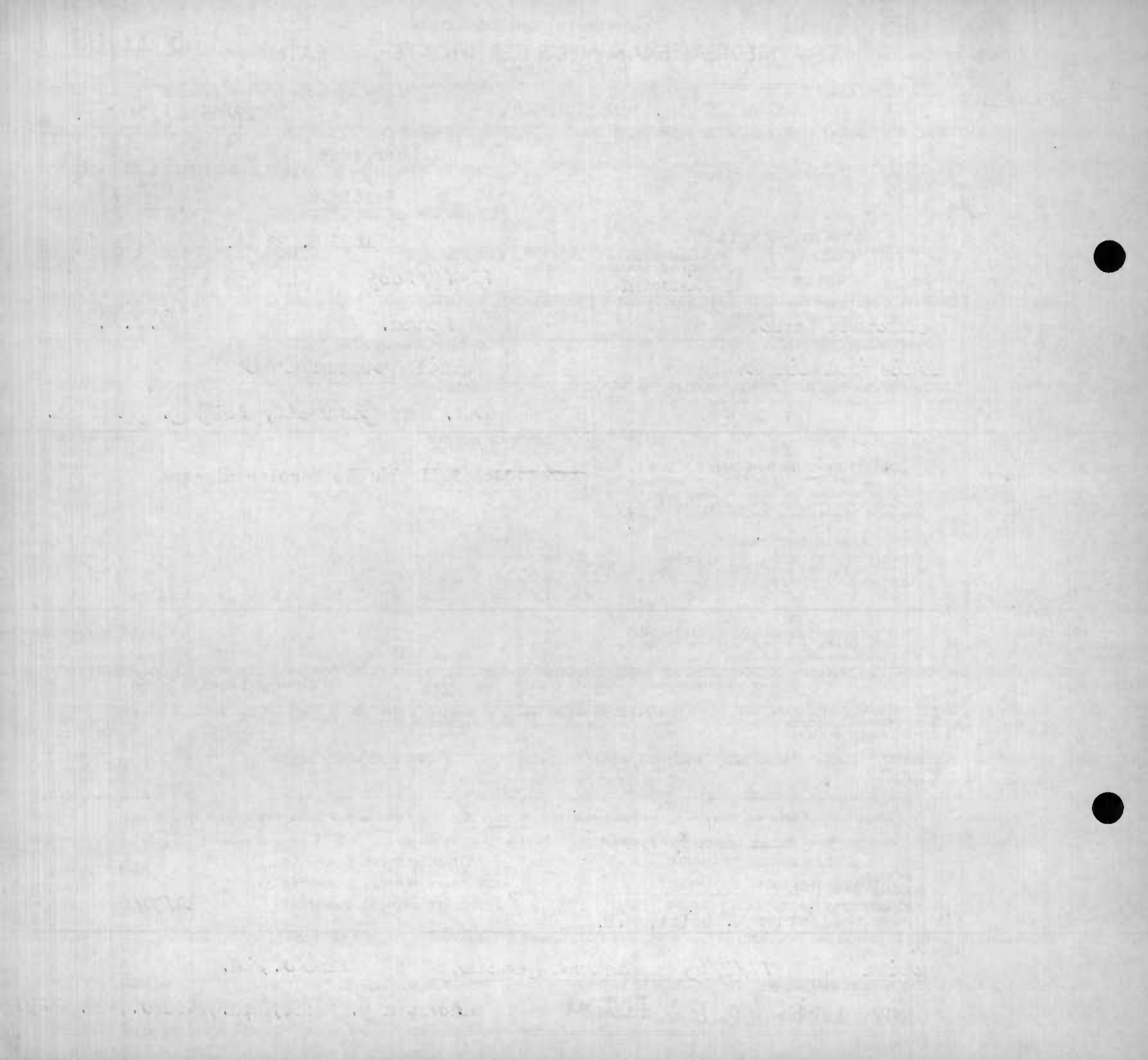
24C. FUNERAL DIRECTOR

ADDRESS

NOV 1 1965

Robert E. Fickel

Leonard J. Ruck, Inc., Balto., Md. 21214



BIRTH NO. 65 11170		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11170	
M.E. CASE NO. B-632					
1. NAME OF DECEASED (Type or Print) THEODORE A. BRATZ			2. DATE AND HOUR PRONOUNCED DEAD 10/30/65 3:15 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 250 5 Hamilton Ave.		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 9/10/1885	9. AGE (In years last birthday) 80	10. Under 1 Yr. If Under 24 Hrs. Months; Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Frederick Bratz			14. MOTHER'S MAIDEN NAME Amalia ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215283171		17. INFORMANT ADDRESS Mrs. Margery Bratz Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/30/65	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 11/3/65		23C. NAME of CEMETERY or CREMATORY Baltimore National	
24A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		24B. NAME OF REGISTRAR Robert E. Fisher		24C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214	
24D. LOCATION Baltimore, Md.		24E. ADDRESS		24F. ADDRESS	

WALLER LONGE



BIRTH NO.

65 11171

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

OSCAR G. RUSSELL

2. DATE AND HOUR PRONOUNCED DEAD

10-29-65

10:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

827 S Pnca St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

10/31/1906

9. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Western Elec.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James B. Russell

14. MOTHER'S MAIDEN NAME

Nellie P. Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216032869

17. INFORMANT

ADDRESS

Mr. Clarence Russell, 112 Leslie Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty cirrhosis of the liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

R. Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-29-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

23B. DATE

11/2/65

23C. NAME of CEMETERY or CREMATORY

Greenmount Cemetery

23D. LOCATION

(City, town, or county)

Balto., Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1965

24B. NAME OF REGISTRAR

Robert E. Farkner

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc., Balto., Md. 21214

ADDRESS

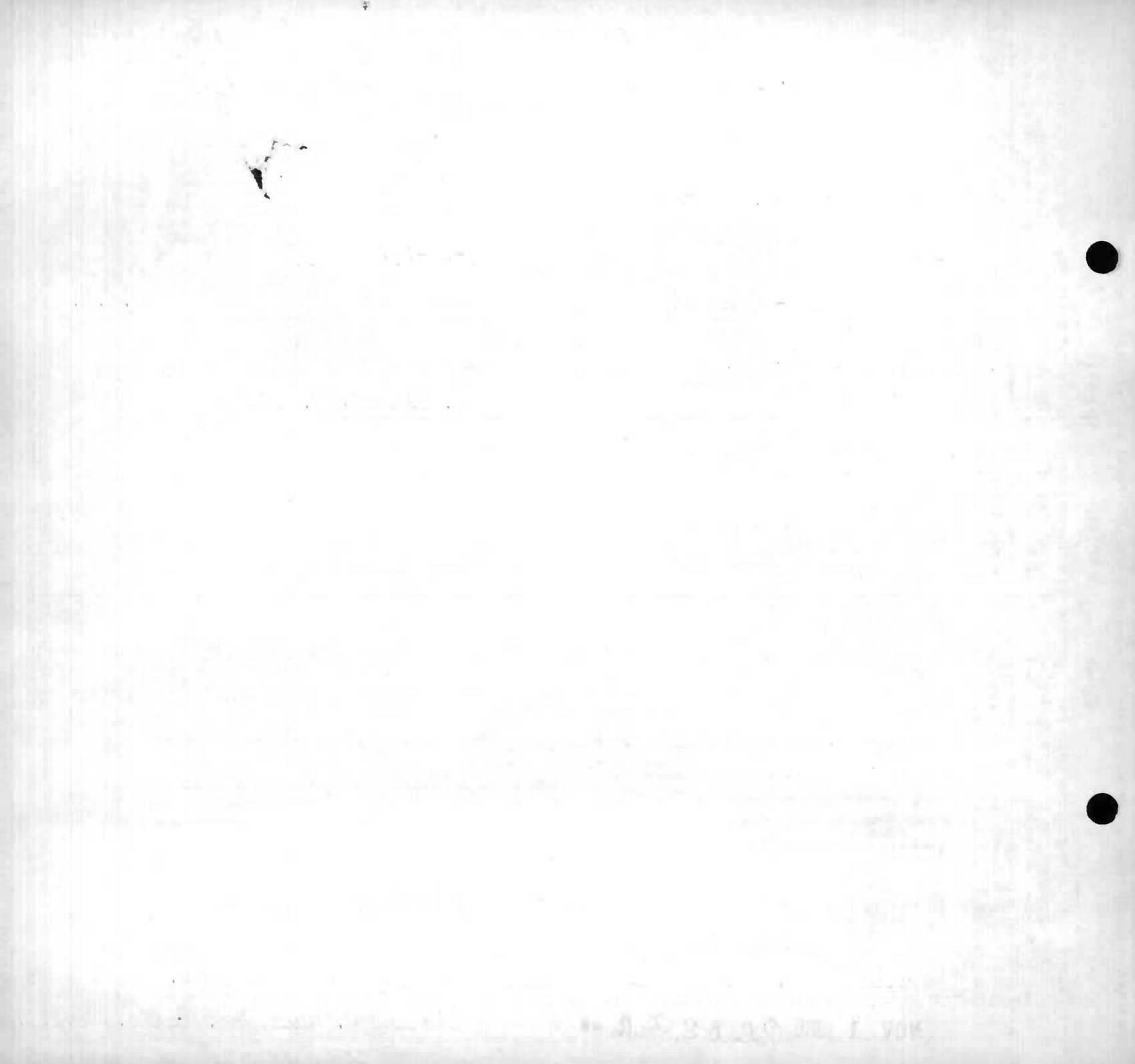


10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11172	
BIRTH NO. 65 11172		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>E. Genevieve Trail</i>		2. DATE AND HOUR OF DEATH <i>October 28, 1965</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>2610 Chesley Avenue</i>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
		D. STREET ADDRESS (If rural, give location) <i>2610 Chesley Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>4-15-1910</i>	9. AGE (In years last birthday) <i>55</i>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper - Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>August Geckle</i>		14. MOTHER'S MAIDEN NAME <i>Mary Eberle</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Francis J. Trail</i>	
				ADDRESS <i>Same</i>	
18. <i>163X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Carcinoma of Lung</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
19. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19 63</i> to <i>Oct 28<sup>th</sup> 19 65</i> , that (I) (we) last saw the deceased alive on <i>Oct 27<sup>th</sup> 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>George H. Beck</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>10/29/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>GEORGE H. BECK</i>		23D. ADDRESS <i>6012 HARFORD ROAD BALTO, MD 21214</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/30/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery Baltimore, Md.</i>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 1 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., Balto., Md. 21214</i>	
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 11173	
BIRTH NO. 65 11173		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Eleanor A. Metzger		2. DATE AND HOUR OF DEATH 10/29/65 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.		A. STATE Md.		B. COUNTY 26-03	
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	
8. DATE OF BIRTH 5/21/97		9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) housewife	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Reinig	
14. MOTHER'S MAIDEN NAME Mary Butta		15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-3372	
17. INFORMANT Jos. H. Metzger, Jr.		ADDRESS Rd. 1543 Rennewick		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Coronary heart disease		INTERVAL BETWEEN ONSET AND DEATH many years	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1:30 AM Oct 29, 1965 to 7:35 AM Oct 29, 1965 and that (I) (we) last saw the deceased alive on Oct 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Nicholas K. Moore		M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/29/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 1 1965		24F. NAME OF REGISTRAR Robert E. Farber, M.D.	
24G. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		24H. ADDRESS 5305 Harford Rd.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>570 65 11174</b>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. <b>65 11174</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>William A. Schoenig</b>				2. DATE AND HOUR OF DEATH <b>October 28, 1965 4:25 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS <b>5945 Blufffield Ave. 4940 Eastern Avenue, #21224</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Married</b>	8. DATE OF BIRTH <b>10-4-1887</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days Hours	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Schoenig</b>				14. MOTHER'S MAIDEN NAME <b>Apollina ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-32-4671</b>		17. INFORMANT ADDRESS <b>RECORDS: BGH, 4940 Eastern Ave., #21224</b>			
18. <b>570.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration with Respiratory and Cardiac Arrest</b>		CAUSE OF DEATH <b>Aspiration with Respiratory and Cardiac Arrest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 Hours</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Mesenteric Arterial Thrombosis with Vomiting</b>		<b>3 -4 Days</b>			
		(B) <b>Chronic Atrial Fibrillation &amp; Emboli secondary to Arterio-Sclerotic Cerebral Vascular Disease</b>		<b>3 -4 Days</b>			
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>November 3, 1964</b> to <b>October 28, 1965</b> , that (I) (we) lost saw the deceased alive on <b>October 28, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. A. Dennis</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-28-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. M. A. DENNIS</b>				23D. ADDRESS <b>M.D. 4940 Eastern Avenue, Baltimore, Md., #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/2/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fadden</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., Balto., Md. 21214</b>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11175				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11175	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Josephine M. Chaney</b>				2. DATE AND HOUR OF DEATH <b>10-27-65</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <b>Md.</b>		B. COUNTY <b>Baltimore</b>	
<b>3742 Elmley Avenue Balt. Md. 21213</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>3742 Elmley Avenue 21213</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10-28-28</b>	9. AGE (In years last birthday) <b>36</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-242-096</b>		17. INFORMANT <b>Robert F. Chaney</b>		
			ADDRESS <b>3742 Elmley Ave. 21213</b>				
18. <b>171X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Anaplastic Carcinoma of the Uterine Cervix</b> (B) <b>DUE TO</b> (C) <b>DUE TO</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>10-30-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>George H. Muller</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-30-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Finken</b>		25C. FUNERAL DIRECTOR <b>Paul E. Chaney</b>		ADDRESS <b>3615 Chestnut</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 11176		65 11176			
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED (Type or Print)</div> <div>2. DATE AND HOUR OF DEATH</div> </div> <div> <div>WATSON, JACQUELINE CAROL</div> <div>10-28-65 4:25A M.</div> </div>					
<div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> <div>ST. AGNES HOSPITAL</div> </div>			<div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div> <div>A. STATE</div> <div>B. COUNTY</div> <div>MARYLAND HOWARD</div> </div> <div> <div>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</div> <div>ELKRIDGE 63-00</div> </div> <div> <div>D. STREET ADDRESS (If rural, give location)</div> <div>6501 HARMAN AVENUE</div> </div>		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-22-35	9. AGE (In years last birthday) 30	<div>If Under 1 Yr. Months Days</div> <div>If Under 24 Hrs. Hours Min.</div>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LESLIE G. TOWNSEND			
14. MOTHER'S MAIDEN NAME VIRGINIA COOL (L.)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ST. AGNES RECORDS-CATON & WILKENS AVE			
<div>18. CAUSE OF DEATH</div> <div> <div>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</div> </div> <div> <div>(A) PULMONARY EDEMA</div> <div>(B) PROB. COLLAGEN DISEASE</div> <div>(C)</div> </div>			<div>INTERVAL BETWEEN ONSET AND DEATH</div>		
<div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div>					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<div>22. I certify that (I) (this hospital) attended the deceased from OCTOBER 23 19 65 to OCTOBER 28 19 65, that (I) (we) last saw the deceased alive on OCTOBER 28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>					
23A. SIGNATURE <i>Manfred Amrhein</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10-28-65	
23C. PHYSICIAN'S NAME (Type) MANFRED AMRHEIN		23D. ADDRESS M.D. CATON & WILKENS AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/1/65		24C. NAME of CEMETERY or CREMATORY MEADOWRIDGE MEMORIAL PARK	
24D. LOCATION BALTIMORE, MARYLAND		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR E. J. [illegible]		25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 11177	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) COOK, JOSEPH LESLIE			2. DATE AND HOUR OF DEATH 10/28/65 11:35 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE M.D. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 25-41 D. STREET ADDRESS (If rural, give location) 3733 CLARNELL RD.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 10/12/02	9. AGE (In years lost birthday) 63	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLARK GUARD		10B. KIND OF BUSINESS OR INDUSTRY UNK		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME ? COOK (D)		
14. MOTHER'S MAIDEN NAME MARGARET CLARK (D)			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 213-70-58101			17. INFORMANT COOK ADDRESS ANNAPOLIS (WIFE) SAME AS ABOVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) CIRRHOSIS, LIVER, SPOT DUE TO (B) BRONCHOPNEUMONIA, Right Lung DUE TO (C)  INTERVAL BETWEEN ONSET AND DEATH rate		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/23/65 to 10/28/65, that (I) (we) last saw the deceased alive on 10/28/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Brown			23B. DATE SIGNED 10/28/65		
23C. PHYSICIAN'S NAME (Type) DR. CHARLES S. BROWN			23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/2/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery Bal To., MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Hubbard Funeral Home 4107 WILKENS AVE.	

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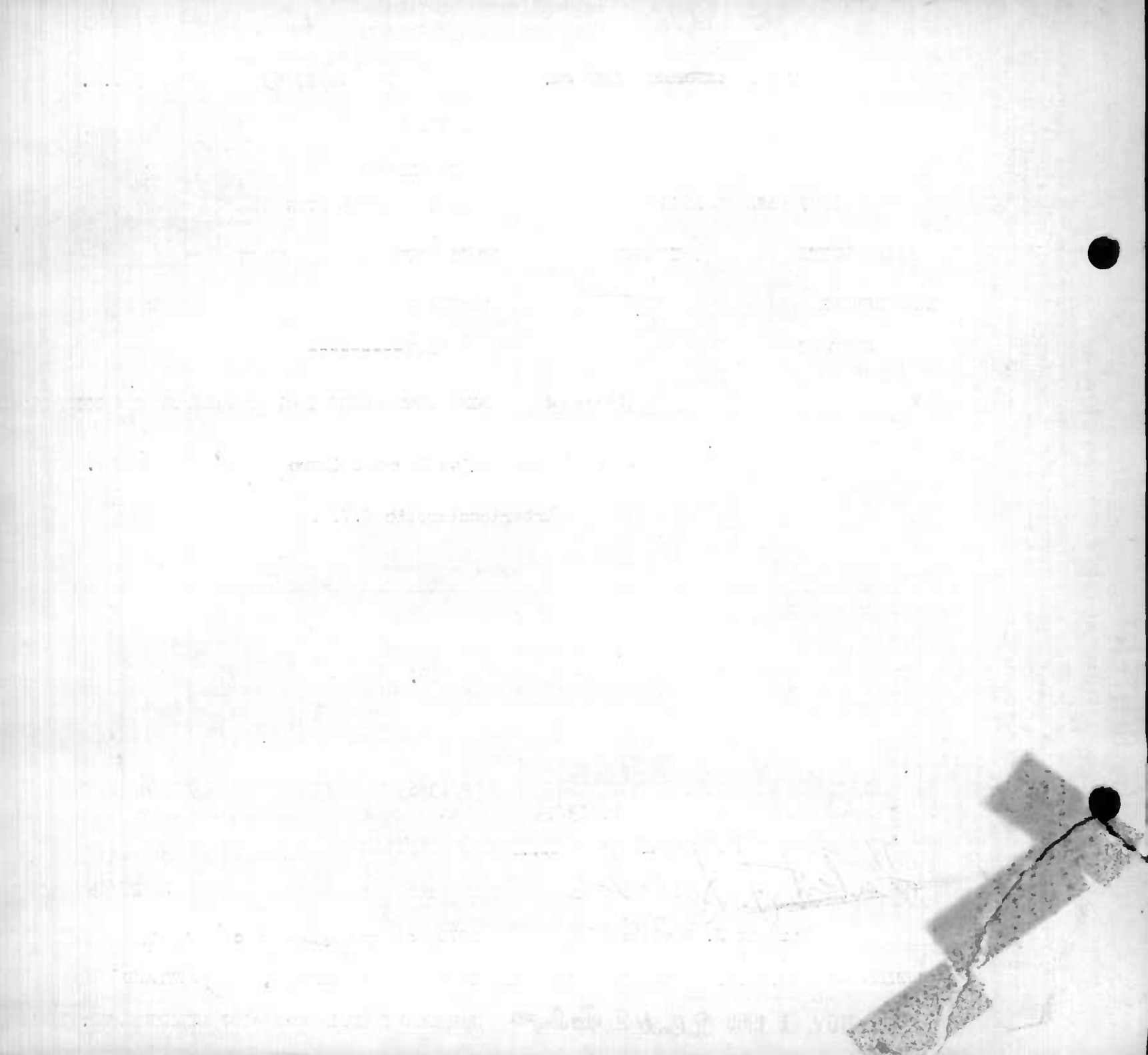
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11178</b>	
BIRTH NO. <b>65 11178</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>THOMAS OWENS</b>		2. DATE AND HOUR OF DEATH <b>10/27/65 5 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1907 CASADEL AVENUE</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>25-52</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1907 CASADEL AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>10/29/1874</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LEAD BURNER</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>MARY-----</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT ADDRESS <b>MISS RUTH OWENS 1907 CASADEL AVENUE XXX 21230</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>422.11</b>		CAUSE OF DEATH (A) <b>Congestive heart failure</b> DUE TO (B) <b>Arteriosclerotic C.V.D.</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks.</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No.</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/13/65</b> 19 to <b>10/23/65</b> 19, that (I) (we) last saw the deceased alive on <b>10/23/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Herbert J. Levickas</b> M.D.				23B. DATE SIGNED <b>10/28/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Herbert J. Levickas</b> M.D.				23D. ADDRESS <b>1073 Maiden Choice Land 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/30/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>MORELAND MEMORIAL PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 1 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

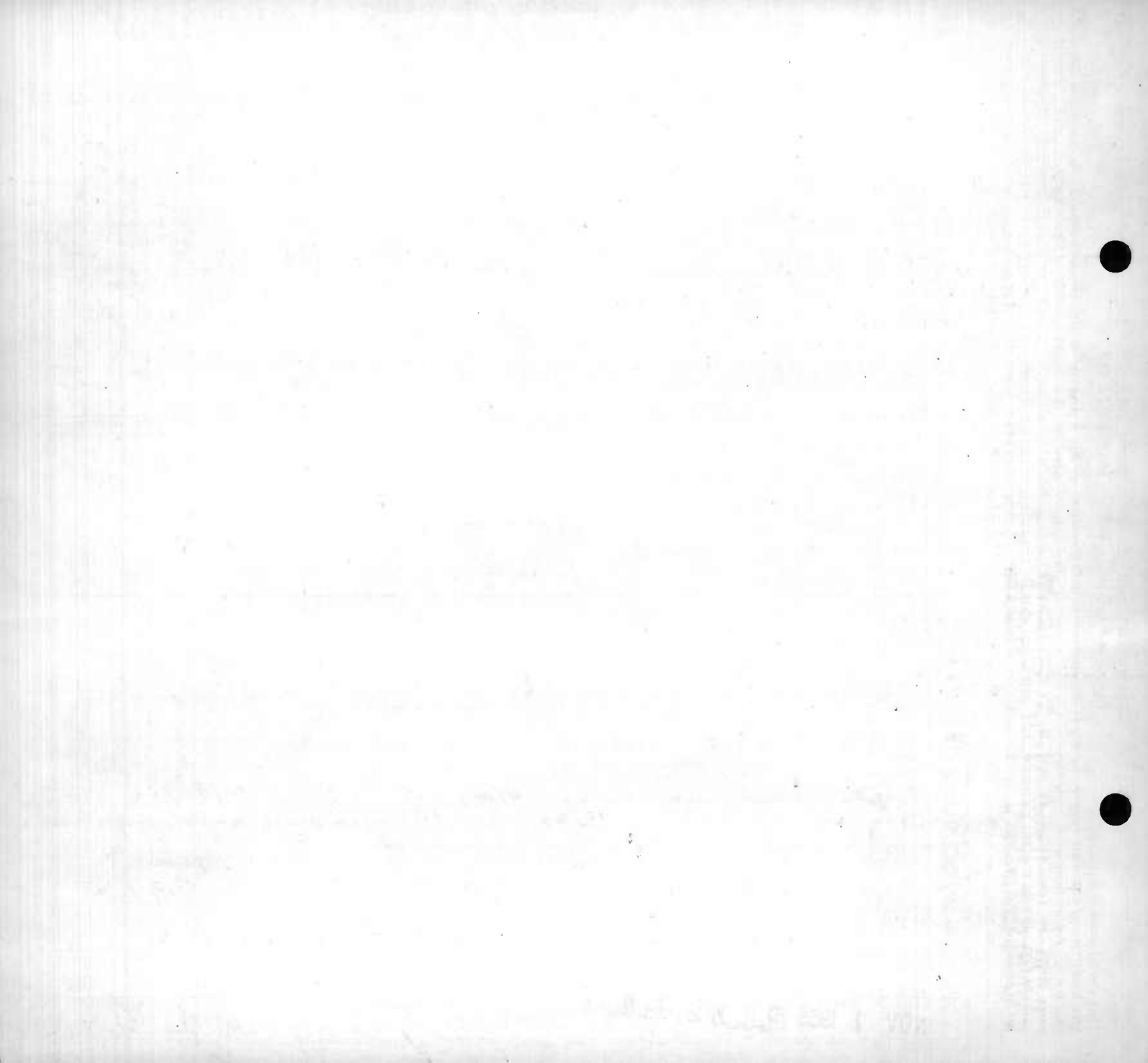
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 5 11179	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Stokes, William N. (Rev.)		2. DATE AND HOUR OF DEATH October 30, 1965 11:15 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		3217 Powhattan Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Oct. 8, 1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pastor		10B. KIND OF BUSINESS OR INDUSTRY New Hope Pastor, Baptist		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Benjamin Stokes		14. MOTHER'S MAIDEN NAME Lucy Scruggs	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Vashti Stokes-wife same	
18. 352X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 8, 19 65 to October 30, 1965, that (I) (we) last saw the deceased alive on October 30, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roger Theodore		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED October 30, 1965	
23C. PHYSICIAN'S NAME (Type) Roger Theodore		23D. ADDRESS 1514 Division Street-Baltimore 17, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE II/4/65		24C. NAME of CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION Brooklyn, A.A.Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR W.I. Chatman, Jr.	
		ADDRESS 1701 McCulloh St.			



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11180	
BIRTH NO. 65 11180		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ruby Phillips</i>		2. DATE AND HOUR OF DEATH <i>10/29/65 9 P.M. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>18-03</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1024 Hollins St.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>1024 Hollins St.</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>12/10/1924</i>	9. AGE (In years lost birthday) <i>40</i>	10. Under 1 Tr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Claudie Bullen</i>		14. MOTHER'S MAIDEN NAME <i>Ann Bragg</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Thomas Phillips Above</i>	
18. <i>171X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>General carcinomatosis</i> DUE TO (B) <i>Carcinoma of cervix</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i> <i>3 mo</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Aug 15</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>pain Cardiac surgery for</i>		20A. AUTOPST? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/15/65</i> 19 to <i>10/30/65</i> 19, that (I) (we) last saw the deceased alive on <i>10/29</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. Calais</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10/29/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. A. Calais</i>		M.D. 23D. ADDRESS <i>6411 Frederick Ave</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>11/2/65</i>	24C. NAME of CEMETERY or CREMATORY <i>Alton Haven Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 1 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Jones</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John J. Cowan &amp; Son Inc. 23 Hollins St.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11181		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11181	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Annie B. Steele		2. DATE AND HOUR OF DEATH 10/31/65 18:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 16-06		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		D. STREET ADDRESS (If rural, give location) 2808 Mosher St.			
5. SEX Fe.	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/5/15	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Durham N.C.	
13. FATHER'S NAME Joseph Smith		14. MOTHER'S MAIDEN NAME Charity Taylor		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 239-24-3246		17. INFORMANT H. Smith 2808 Mosher St	
18. 446X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Uremia DUE TO (B) Arterio-arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1) Pneumonia 2) Laennec's Cirrhosis					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 24, 1965 to October 31, 1965, that (I) (we) last saw the deceased alive on October 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert C. Blackman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/31/65	
23C. PHYSICIAN'S NAME (Type) Robert C. Blackman		M.D. 23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-3-65		24C. NAME of CEMETERY or CREMATORY Durham N.C.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR R. E. Taylor	
25C. FUNERAL DIRECTOR P. Wainwright		ADDRESS 2700 Edmondson Ave.			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 11182		CERTIFICATE OF DEATH		65 11182	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		KNIEPKEMP CAROLINE		10/30/65 9 <sup>45</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
4 South Baltimore General Hospital		Maryland Baltimore		23-02	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
F		W		WIDOWED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife				May 30, 1890	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years lost birthday)	
John Eaton		Alverta Burns		75	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217 09 1160		Mr. Wm. A. Walker 407 Waverly Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.11x260X		Arteriosclerotic Cardiovascular Disease			
19. ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
II		(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/29 1965 to 10/30 1965, that (I) (we) lost saw the deceased alive on 10/30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Robert R. Holthaus				10/30/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ROBERT R. HOLTHAUS		S. BALTO. GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11 3 1965		Cedar Hill	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 2 1965		Robert E. Johnson		McGully 130 E. Fort Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11183		CERTIFICATE OF DEATH		Registered No. 65 11183	
1. NAME OF DECEASED (Type or Print) <b>LIEBLER, MR. LEONARD</b>				2. DATE AND HOUR OF DEATH <b>10-31-65 10:00 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME &amp; HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>GLENMORE AVE. BALTO. 6</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 53-00</b> D. STREET ADDRESS (If rural, give location) <b>4504 Glenmore Avenue #6</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>12-25-86</b>		9. AGE (In years last birthday) <b>78</b>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MEAT PACKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MEAT PACKING CO.</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>JACOB LIEBLER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET HEIDT</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-0438</b>		17. INFORMANT <b>Mrs Johanna Liebler 4504 Glenmore Avenue</b>				ADDRESS	
18. <b>131X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <b>CANCER OF THE STOMACH</b> DUE TO (B) <b>MALNUTRITION</b> DUE TO (C) <b>METASTASIS &amp; OBSTRUCTION</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>11-11-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GASTRIC ANTRUM OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No) <b>(No)</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10-11</b> 19 <b>65</b> to <b>10-31</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10-31</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Jose Y Ortiz</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-31-65</b>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>M.D.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>11-3-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>		25C. FUNERAL DIRECTOR <b>Lazarus Funeral Home 7401 Belton Road</b>		ADDRESS (36)			

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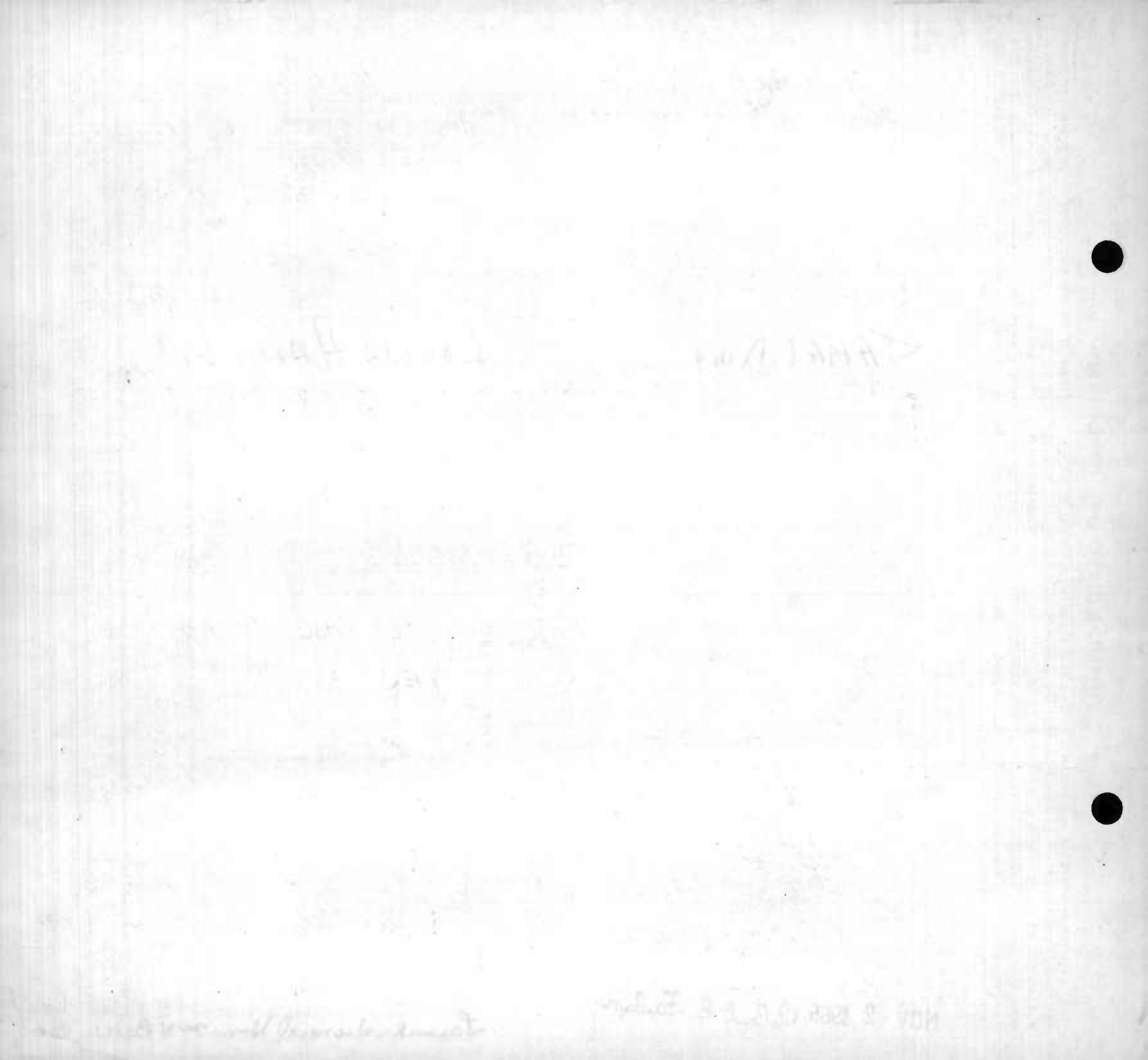
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11184		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11184	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HOWARD KING</b>		2. DATE AND HOUR OF DEATH <b>10/31/65</b> <b>2:00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>MIDDLE RIVER</b> <b>53-00</b>			
		D. STREET ADDRESS (If rural, give location) <b>1 KINGSTON PARK ROAD</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>12/27/83</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES King</b>			
14. MOTHER'S MAIDEN NAME <b>LOUISA HANNIGAN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>217-07-4633</b>		17. INFORMANT ADDRESS <b>Mr Howard J. King Jr. 1 Kingston Park Rd</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIORESP ARREST</b>		INTERVAL BETWEEN ONSET AND DEATH <b>0</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>? ACID-BASE ABNORMALITY</b>		<b>HOURS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ATHEROSCLEROTIC VASC DISEASE</b>		<b>HOURS - DAY</b>			
19A. DATE OF OPERATION <b>2-5</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>0</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 30 1965</b> to <b>October 31 1965</b> , that (I) (we) last saw the deceased alive on <b>10/31 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Gregory Kane</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/31/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Gregory Kane</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-3-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Co. Md.</b>		25A. DATE RECD BY HEALTH DEPT <b>NOV 2 1965</b>			
25B. NAME OF FUNERAL DIRECTOR <b>E. J. J. J.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>LaSalle Funeral Home 7401 Belair Road</b>			

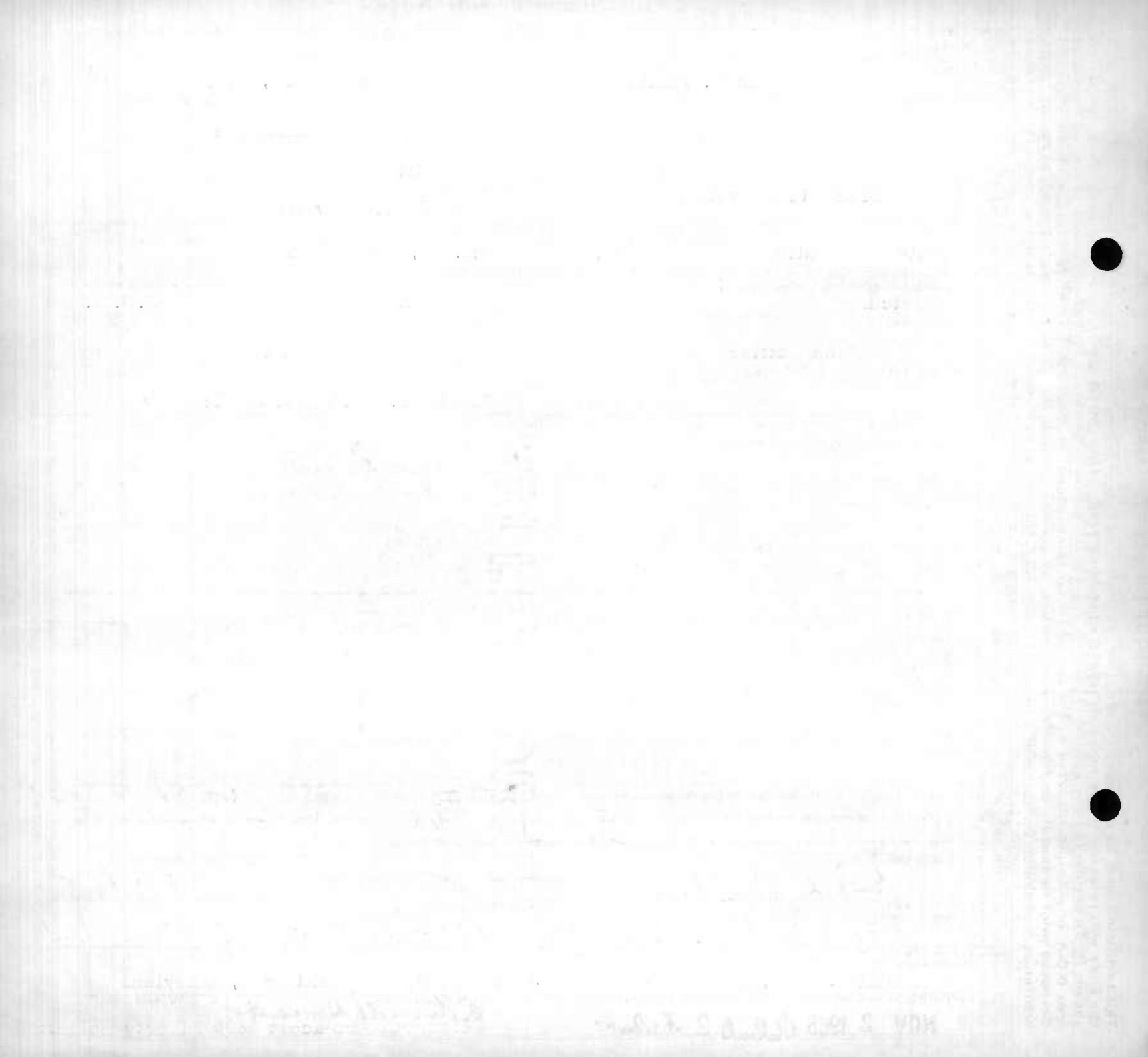


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65-11185</b>	
BIRTH NO. <b>65 11185</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>John P. Lattier</b>		2. DATE AND HOUR OF DEATH <b>October 31, 1965</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3503 Hicks Avenue</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3503 Hicks Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 27, 1879</b>
9. AGE (In years last birthday) <b>86</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lattier</b>		14. MOTHER'S MAIDEN NAME <b>Melking</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Carrie M. Lattier</b>		ADDRESS <b>3503 Hicks Avenue</b>	
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(1) Arterio Sclerosis</b> <b>Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Generalized Arterio Sclerosis</b>			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 29 - 1965</b> to <b>Oct. 31 - 1965</b> . that (I) (we) last saw the deceased alive on <b>Oct. 29 - 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Earl L. Chambers</b>		23B. DATE SIGNED <b>11/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		23D. ADDRESS <b>4108 Liberty Hg. - Balto. - Md.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/3/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		ADDRESS <b>4600 Liberty Heights</b>	

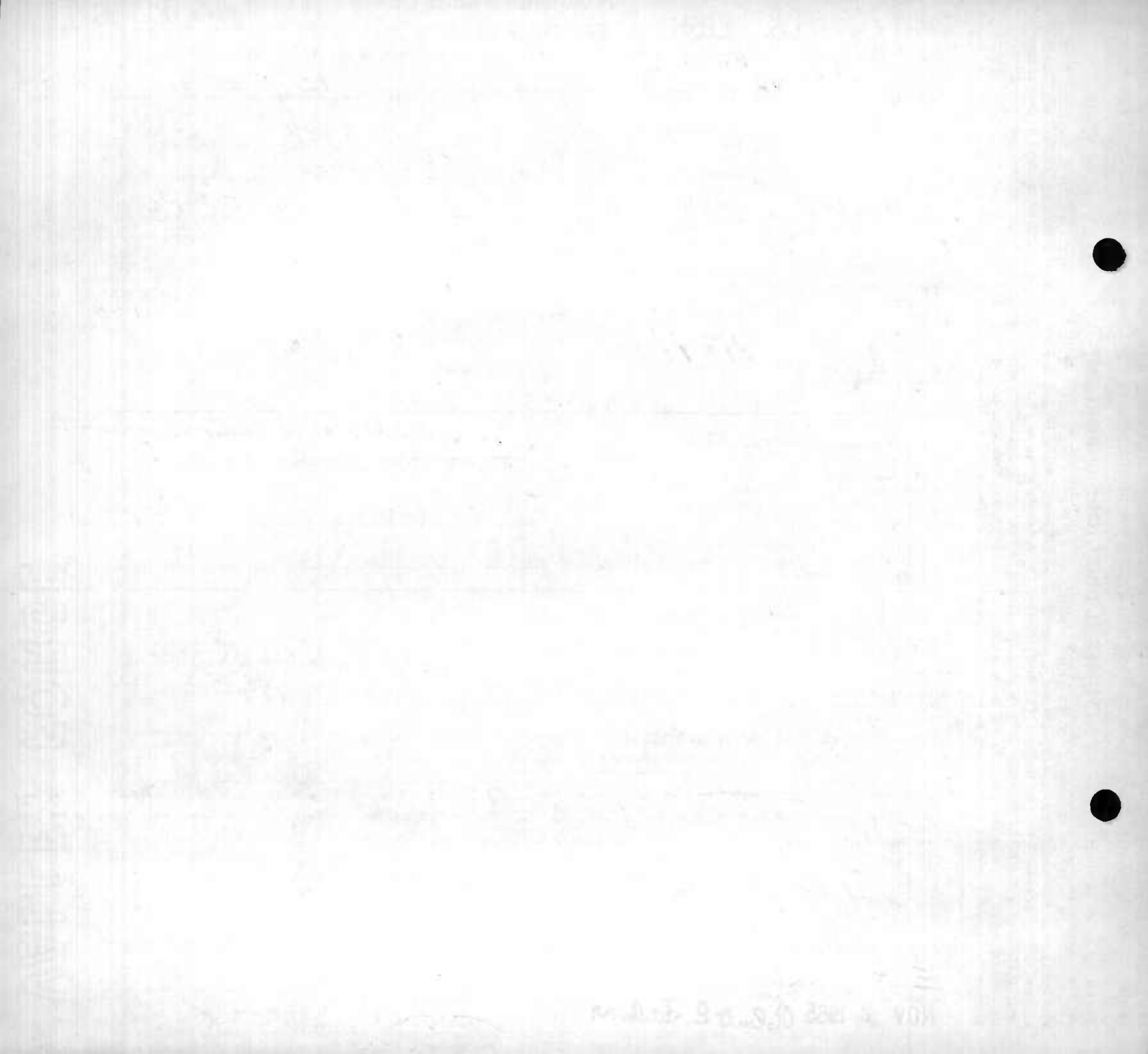




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 11186</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11186</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Ade laide AJELRADE Tetramani</b>		2. DATE AND HOUR OF DEATH <b>1-Nov 65 7:20 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1-02</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>107 S Rochester PL</b>			
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2-15-87</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>NATURALIZED CITIZEN USA</b>		13. FATHER'S NAME <b>FRANK Pizziti</b>		14. MOTHER'S MAIDEN NAME <b>ROSA (unknown)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Hospital Chart</b>	
18. <b>330X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Sub ARACIT NOID Hemorrhage</b>		CAUSE OF DEATH (A) <b>CAUSE of Vascular Accident</b> DUE TO (B) <b>Hyper tension -</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>10 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>(If in Baltimore City, give exact location)</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. WHERE DID INJURY OCCUR?		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from <b>10-23-1965</b> to <b>1-Nov-1965</b> , that (we) lost saw the deceased alive on <b>1-Nov-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>T.C. Cullis mp</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-Nov-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>T.C. Cullis</b>		23D. ADDRESS <b>MARYLAND GENERAL Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Baltimore Md 4, 1965</b>		24B. DATE <b>Nov 4, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Ph. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas, MD</b>		25C. FUNERAL DIRECTOR <b>Joseph X. Zannini 263 S. Clarking St</b>	
ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>20</b>		65 11187		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11187</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>L. RUTH HOLMES</b>				2. DATE AND HOUR OF DEATH <b>10-30-65</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>LINTHICUM HEIGHTS, A.A. Co. 52-00</b> D. STREET ADDRESS (If rural, give location) <b>703 SHIPLEY COURT</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>3-3-01</b>	9. AGE (in years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Johns Hopkins University</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>BENEDICT LOEVY</b>				14. MOTHER'S MAIDEN NAME <b>MAY C. REDHEFFER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>506 03 7001</b>		17. INFORMANT <b>Allen Holmes, 703 Shipley Crt. zone 20</b>		ADDRESS <b>21090</b>	
18. <b>180X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Respiratory Arrest</b> DUE TO (B) <b>Anemia 20 to</b> DUE TO (C) <b>Hypertension &amp; Metastases</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pericardial Myocardial Infarction</b>							
19A. DATE OF OPERATION <b>2 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 13</b> 19 <b>65</b> to <b>Oct. 30</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Oct. 30</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Charles T. Kaelber</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/30/65</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.O.			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>Nov. 2/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Crematory</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D. 4101 Edmondson Ave</b>		ADDRESS	

1941

1941

1941

1941

65 11188

BALTIMORE CITY HEALTH DEPARTMENT

65 11188

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MAMIE A. SHIFFLET T

2. DATE AND HOUR PRONOUNCED DEAD

10/29/65 10:05 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

915 W. Baltimore St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10/13/1920

9. AGE (In years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
USA AT COUNTRY?

13. FATHER'S NAME

Elmer Bowen

14. MOTHER'S MAIDEN NAME

Elizabeth Warner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 581.04-1002.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Fatty liver

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Caseous cavitory pulmonary tuberculosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN IDENTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/30/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

23B. DATE

Nov. 3/65

23C. NAME of CEMETERY or CREMATORY

Balto. National

23D. LOCATION

Balto. Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1965

24B. NAME OF REGISTRAR

Robert E. Farkner

24C. FUNERAL DIRECTOR

Witzke F.D. 4101 Edmondson Ave

ADDRESS

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																								
65 11189					CERTIFICATE OF DEATH					Registered No. 65 11189														
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH									
					Emily L. Anders					10/28/65					M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hosp.										A. STATE Md. B. COUNTY Baltimore														
(If not in hospital or institution, give street address or location)										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Middle River 53-00														
										D. STREET ADDRESS (If rural, give location) 205 Glider Drive														
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 10/10/95		9. AGE (In years last birthday) 70		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY AT HOME				11. BIRTHPLACE (State or foreign country) Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.												
13. FATHER'S NAME Terany Hadell										14. MOTHER'S MAIDEN NAME Easter Adline														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 224-18-4375					17. INFORMANT Daughter (same as above)					ADDRESS									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.11 + 260x										CAUSE OF DEATH (A) Acute coronary occlusion DUE TO (B) arteriosclerotic coronary vessel dis DUE TO (C)										INTERVAL BETWEEN ONSET AND DEATH 1 hour 15 gm				
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from Feb 25 1957 to Oct 28 1965, that (I) (we) last saw the deceased alive on Oct 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																								
23A. SIGNATURE Louis Semenovff										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 10/29/65									
23C. PHYSICIAN'S NAME (Type) LOUIS SEMENOFF										23D. ADDRESS M.D. 2108 OREMS RD, Balto 20, MD														
24A. BURIAL CREMATION, REMOVAL (Specify) Removal					24B. DATE 10/30/65					24C. NAME OF CEMETERY or CREMATORY NEXT CREEK COMMUNITY					24D. LOCATION (City, town, or county) (State) Next Creek Va.									
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965					25B. NAME OF REGISTRAR Robert E. Fisher, M.D.					25C. FUNERAL DIRECTOR Connolly 300 Nace Ave. Balto 21					ADDRESS									



1  
S-420

65 11190

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11190

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM SLAICH

2. DATE AND HOUR PRONOUNCED DEAD

10/29/65 10:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

344 S. Bouldin St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

344 S. Bouldin St.

5. SEX  
male

6. RACE  
white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
MARRIED

8. DATE OF BIRTH

5/14/1905

9. AGE (In years  
last birthday) 60

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PAINTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BAKTO, MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

ALBERT SLAICH

14. MOTHER'S MAIDEN NAME

ROSE NOVAK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ELIZ SLAICH

ADDRESS

SAME AS ABOVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)  
yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN DETERMINING CAUSES OF DEATH?  
yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/30/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11/3/65

23C. NAME of CEMETERY or CREMATORY

SACRED HEART

23D. LOCATION

BAKTO, MD.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1965

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

John J. Connelly, 300 Macaulay St.

ADDRESS

VALLEY GEORGE

PA. COUNTY

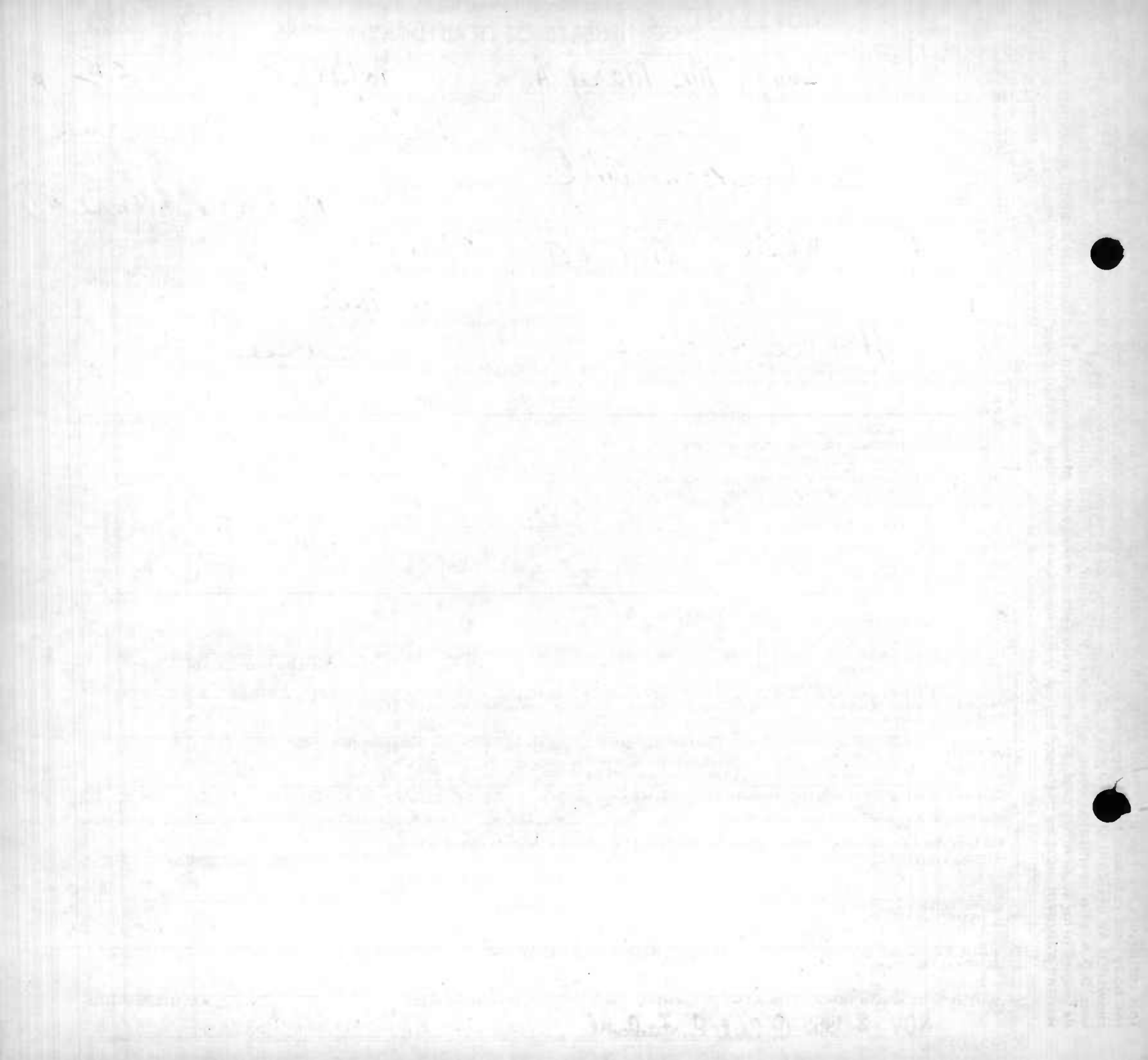
1864

1864

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11191		CERTIFICATE OF DEATH		Registered No. 65 11191	
1. NAME OF DECEASED (Type or Print) <b>Long, Mrs. Mary A.</b>				2. DATE AND HOUR OF DEATH <b>10/28/65 5 15 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bon Secours hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore, Maryland</b> By COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>26-02</b> D. STREET ADDRESS (If rural, give location) <b>4305 Nicholas Avenue #6</b>					
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>5/21/93</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>2.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>2.</b>			11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Horace H. Hale</b>				14. MOTHER'S MAIDEN NAME <b>Haynie</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>215-34-0653</b>		17. INFORMANT <b>Hospital Record</b>			ADDRESS	
18. <b>422.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Acute heart failure -</b> DUE TO (B) <b>Myocardial insufficiency</b> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 12 1965</b> to <b>Oct-28 1965</b> , that (I) (we) last saw the deceased alive on <b>Oct 28 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Juan F. Sordo</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Oct-28-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>JUAN F. SORDO</b>				23D. ADDRESS <b>BON SECOURS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Beithelme Church</b>		24D. LOCATION (City, town, or county) (State) <b>Kilmarnock Va</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Harry N. Unsworth</b> 4204 Ridge Road, Balt. Md. 21215					



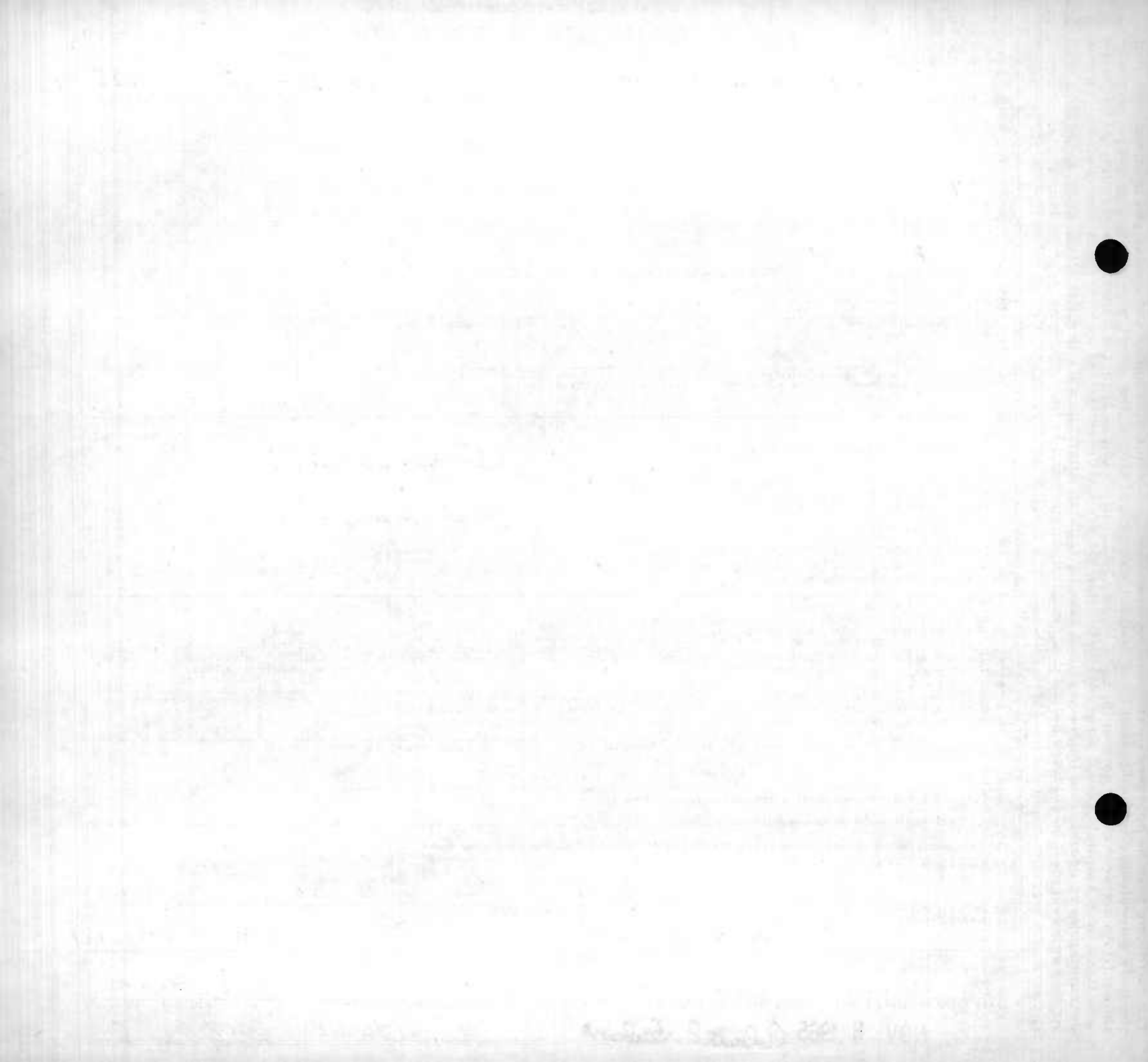


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11192				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11192	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>YONCHA, ALICE M (Alexandra)</b>				2. DATE AND HOUR OF DEATH <b>10-30-65 3:25 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Md.</b>		B. COUNTY <b>28-04</b>	
5. SEX <b>F</b>				6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED <b>MARRIED</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		8. DATE OF BIRTH <b>11-27-99</b>		9. AGE (in years last birthday) <b>65</b>	
11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Balt. Kauskas, Alexander</b>				14. MOTHER'S MAIDEN NAME <b>Dirmetis, Magdelive</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daughter - Regina Yonda - Same</b>	
18. <b>584X I</b>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <b>Cholelithiasis</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Renal Failure (Post-Op.)</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-23-65</b> to <b>10-30-65</b> , that (I) (we) last saw the deceased alive on <b>10-30-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. C. Linantud, Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-30-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. C. LINANTUD, JR.</b>				23D. ADDRESS <b>Bon Secours Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/3/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Bethesda</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>John Cowan + Son Inc.</b>		ADDRESS <b>Bethesda, Md.</b>	

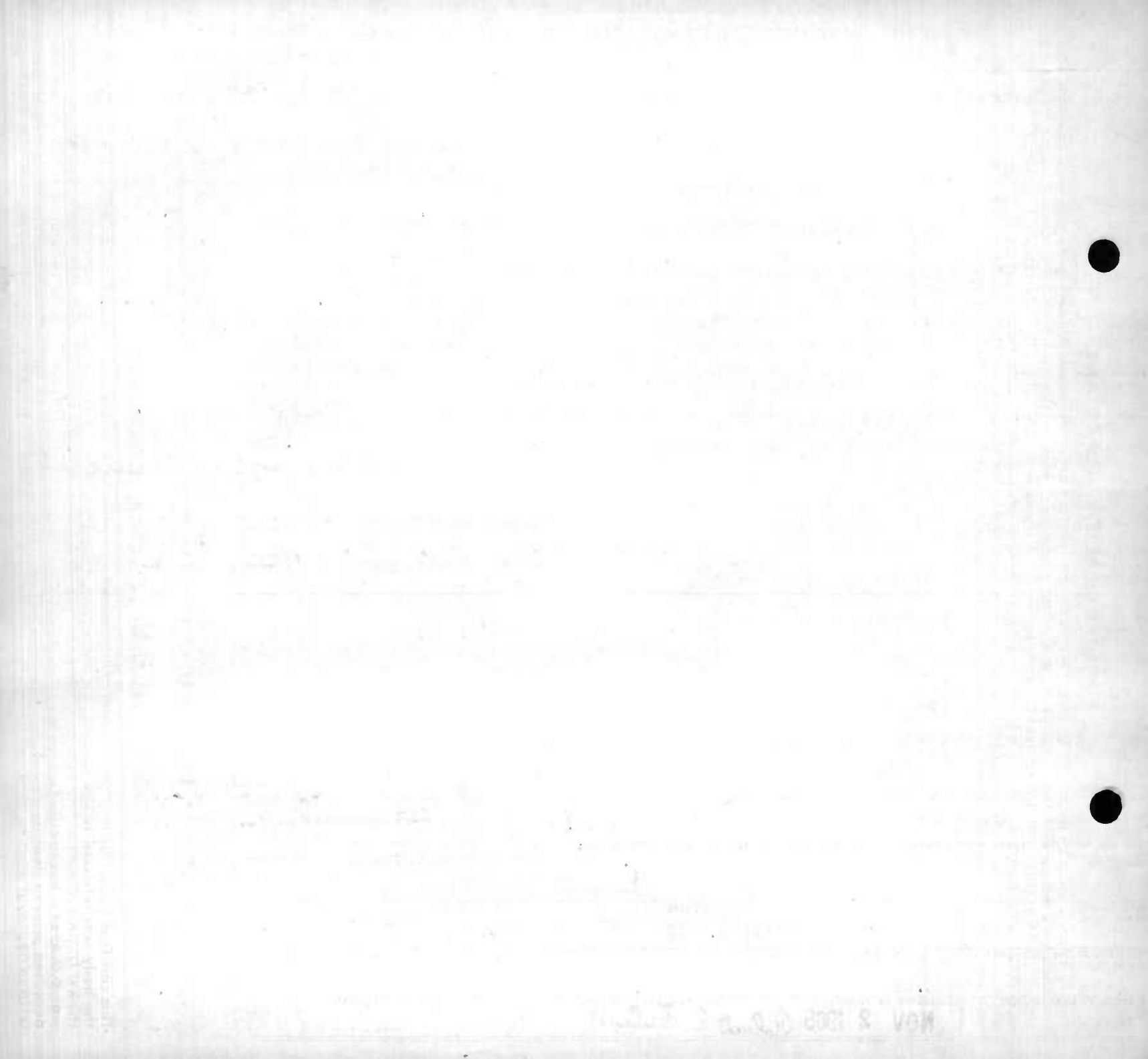




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11193	
BIRTH NO. 65 11193		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George Michael Holmes		2. DATE AND HOUR OF DEATH October 30, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5223 Linden Heights Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June-17-1894	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10B. KIND OF BUSINESS OR INDUSTRY August Stapf		11. BIRTHPLACE (State or foreign country) Baltimore Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Holmes			14. MOTHER'S MAIDEN NAME Josephine Kellar		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-32-8726		17. INFORMANT Margaret Carr, Rock Hall Md. 21661	
18. 502101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Coronary Occlusion DUE TO (B) Emphysema DUE TO (C) Chr. Arteriosclerotic Bronchitis		INTERVAL BETWEEN ONSET AND DEATH Immediate	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from May 28, 1965 to Sept 29, 1965, that (I) (we) last saw the deceased alive on 9/29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Leslie N. Gay		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/1/65	
23C. PHYSICIAN'S NAME (Type) LESLIE N. GAY,		23D. ADDRESS M.D. 1114 St. Paul St. Balto. Md			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/3/65		24C. NAME of CEMETERY or CREMATORY St. Pauls Cemetery	
				24D. LOCATION (City, town, or county) (State) Chestertown, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Harry W. Wincod	
				ADDRESS 4204 Ridgewood Ave Baltimore, Md. 21215	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 11194</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 11194</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <span style="font-size: 1.2em;">65 11194</span>					
1. NAME OF DECEASED (Type or Print) <b>Fialkowski, Stephen</b>		2. DATE AND HOUR OF DEATH <b>October 29, 1965 9: P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>North Charles General Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1000 Skennwood Ave. 21224</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>8-16-14</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locker man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>City of Balto. Park</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>usa</b>		13. FATHER'S NAME <b>Stephen J. Fialkowski Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Marie Wisbeck</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>214-30-7172</b>		17. INFORMANT ADDRESS <b>Marie E. Fialkowski 1000, S. Kenwood Ave. Hospital Record</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		CAUSE OF DEATH (A) <b>Acute Myocardial Infarction</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Few hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 29, 1965</b> to <b>October 29, 1965</b> , that (I) (we) last saw the deceased alive on <b>9 PM Oct. 29, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Seymour Rubin</i>		23B. DATE SIGNED <b>10-29-65</b>		23C. PHYSICIAN'S NAME (Type) <b>Seymour Rubin</b>	
23D. ADDRESS <b>3136 Harford Road, 21218</b>		23E. MED. DIRECTOR <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov. 2, 1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>			
25B. NAME OF REGISTRAR <i>Robert E. Fialkowski</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Dippel Brothers Inc. 1800 E. Lombard St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
65 11195					CERTIFICATE OF DEATH		Registered No. 65 11195		
BIRTH NO. 65 11195					2. DATE AND HOUR OF DEATH October 28, 1965 1 625 P.M.				
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HENRY THOMAS					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 14-03				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAL HOSPITAL OF BALTIMORE BALTIMORE MD					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY				
D. STREET ADDRESS (If rural, give location) 1801 MADISON AVE									
5. SEX MALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH April 17, 1895		9. AGE (In years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDENING		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry R. Thomas					14. MOTHER'S MAIDEN NAME SARA E. OLIVER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 218-034584		17. INFORMANT Joseph R. Thomas Baltimore Md.		
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) Right cerebral vascular accident 9hrs DUE TO Brain Stenosis (B) Intra cerebral hemorrhage DUE TO (C) Hypertension			INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Oct 28 1965 to Oct 28 1965, that (I) (we) last saw the deceased alive on Oct 28, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Allen A. Judman					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 29 Oct 1965	
23C. PHYSICIAN'S NAME (Type) ALLEN H. JUDMAN					23D. ADDRESS SINAL HOSPITAL OF BALTIMORE BALTIMORE MD.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-65		24C. NAME OF CEMETERY or CREMATORY Royal Oak		24D. LOCATION (City, town, or county) (State) Tolbat Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR James B. Washell		ADDRESS Easton Md.			

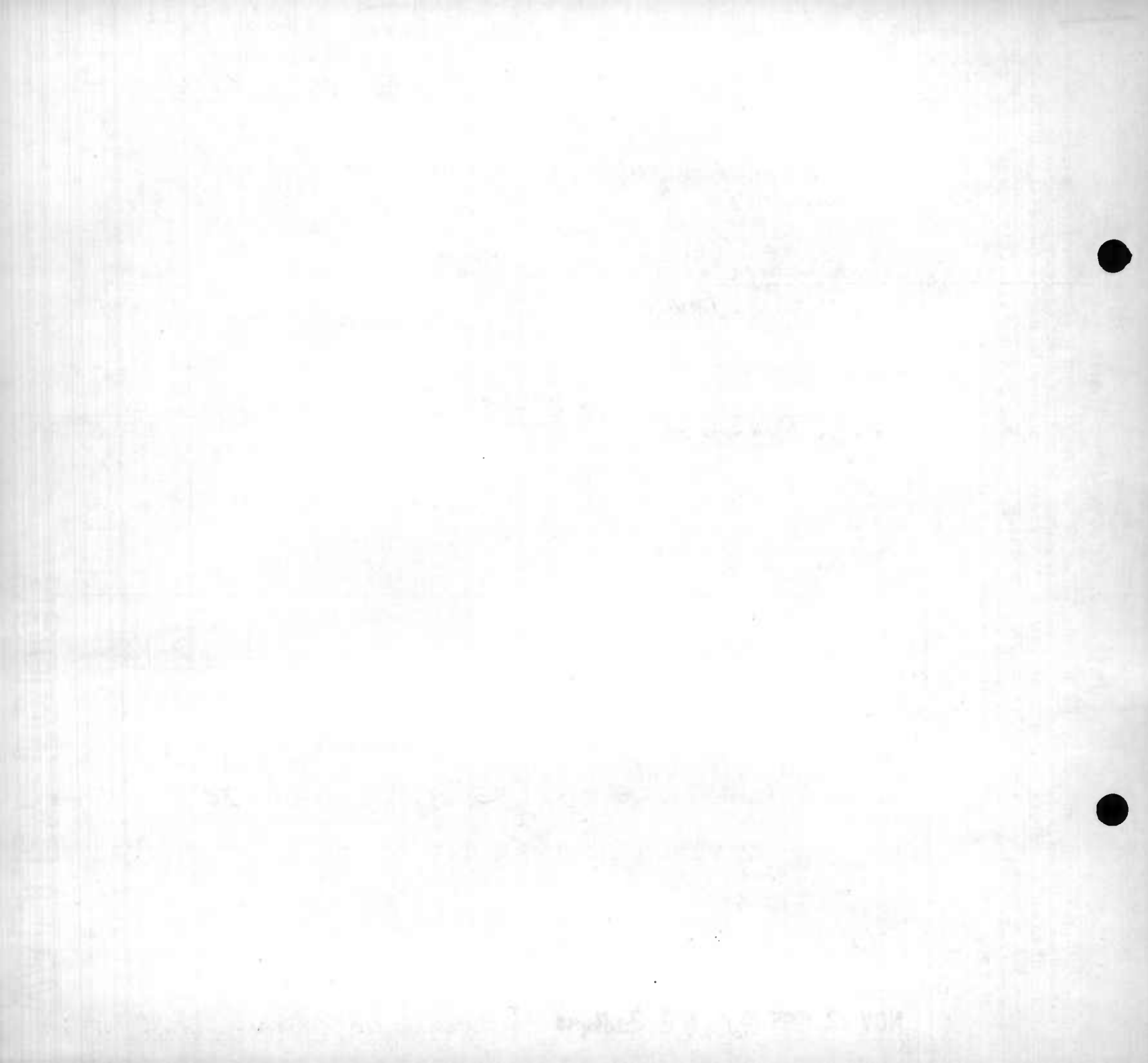




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>65 11196</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11196</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>ZOFIA</b>		2. DATE AND HOUR OF DEATH <b>10/30/65 9:AM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2112 FLEET ST. BALTO. MD. 21231</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>FOY</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>2112 FLEET ST. 21231</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>MAY 15, 1895</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAVERN OWNER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TAVERN</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>POLAND</b>		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>317-34-7612</b>		17. INFORMANT <b>WALTER NAGRABSKI</b> ADDRESS <b>108 S. CASTLE ST. BALTO. MD. 21231</b>			
18. <b>743X + 260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Accident</b>		CAUSE OF DEATH (A) DUE TO <b>A.C.V.D. - Arterio Sclerotic Lesion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 Hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis</b>		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/19/1962</b> to <b>10/30/65</b> 19____, that (I) (we) last saw the deceased alive on <b>10/30/65</b> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mitchell F. Kunkowski</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>MITCHELL F. KUNKOWSKI</b>		23D. ADDRESS <b>2529 Eastern Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-2-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fialkowski</b>		25C. FUNERAL DIRECTOR <b>Wm. A. Fialkowski</b> ADDRESS <b>2007 EASTERN AVE BALTO. 31, MD.</b>	



Hospital will do - part - released by approval of Med Examiner  
Dr. H. P. Stone

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11197		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11197	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John E. Ellwood.		2. DATE AND HOUR OF DEATH 10/31/65 1 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		2817 Daniels Avenue		Baltimore	
5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) singular	
8. DATE OF BIRTH 11-28-99		9. AGE (In years lost birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN (Ret.)	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Stephen C. Ellwood	
14. MOTHER'S MAIDEN NAME Elizabeth Murphy		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 23-38-6734	
17. INFORMANT Hospital Records		ADDRESS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)	
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		20. CAUSE OF DEATH (A) Fibrino-purulent peritonitis following perforation of duodenal peptic ulcer		INTERVAL BETWEEN ONSET AND DEATH < 24 hrs.	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. I certify that (I) (this hospital) attended the deceased from 10/30/65 to 10/31/65 and that (I) (we) lost saw the deceased alive on 10/30/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE J. E. Kelly, Jr. M.D. Attending Phys. Med. Director Staff Phys. 10/31/65	
24. BURIAL CREMATION, REMOVAL (Specify) Burial		25. DATE 11-3-65		26. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM	
27. LOCATION (City, town, or county) Baltimore		28. STATE MD		29. DATE REC'D BY HEALTH DEPT. NOV 2 1965	
30. NAME OF REGISTRAR Robert E. Fickman		31. FUNERAL DIRECTOR CHAS. F. EVANS, Son		32. ADDRESS 8802 Hartford Rd	

13

*[Faint handwritten notes, possibly "13" and "14"]*

*[Faint handwritten notes, possibly "15" and "16"]*

*[Faint handwritten notes, possibly "17" and "18"]*

*[Faint handwritten notes, possibly "19" and "20"]*

*[Faint handwritten notes, possibly "21" and "22"]*

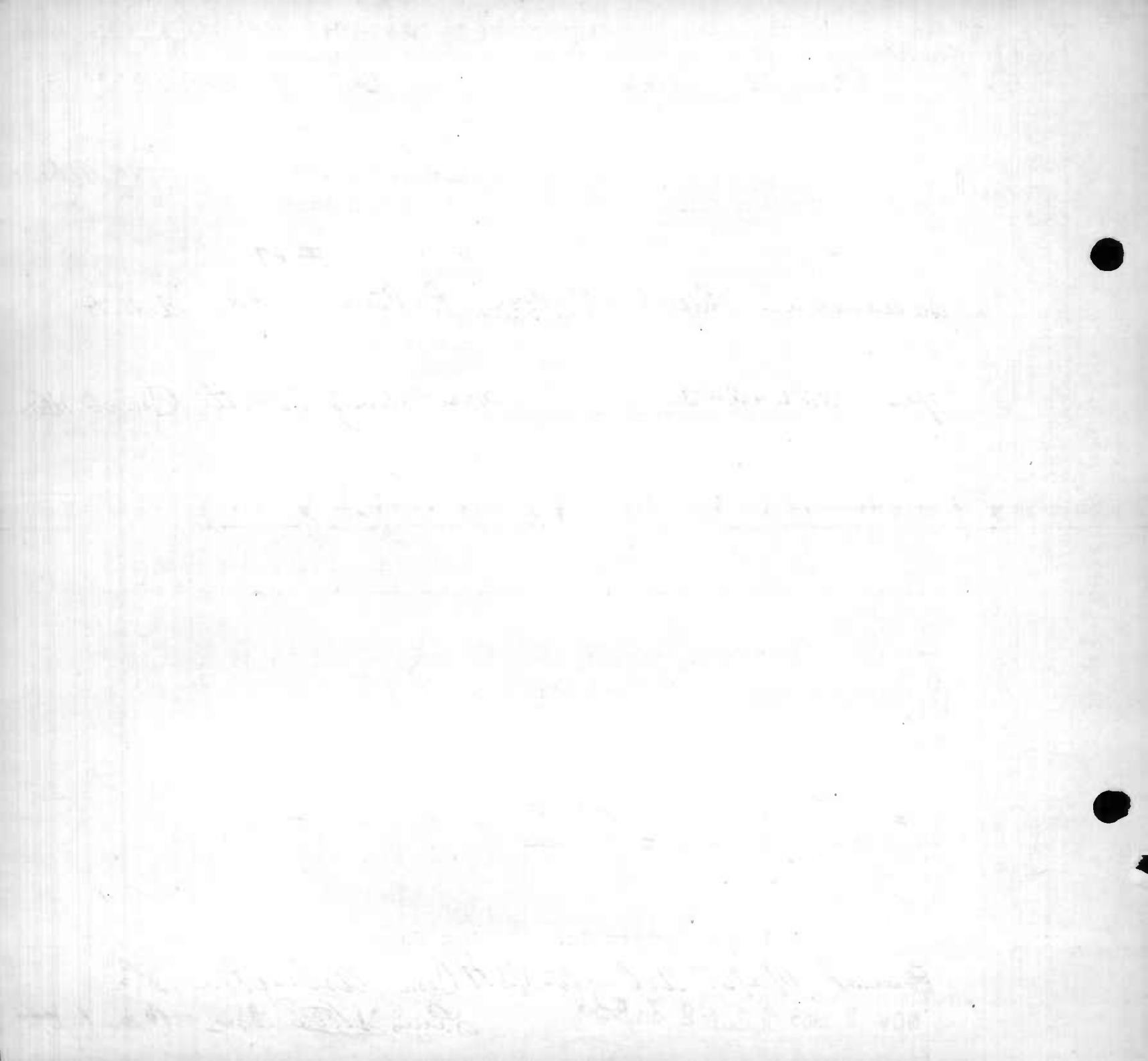
*[Faint handwritten notes, possibly "23" and "24"]*

*[Extremely faint handwritten notes covering the right half of the page, mostly illegible]*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11198		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11198	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Streett, John J.</u>				2. DATE AND HOUR OF DEATH <u>Oct. 28, 1965 3:45 A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <u>MD.</u>		B. COUNTY <u>Allegany</u>	
The Johns Hopkins <del>HOSPITAL</del> Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Cumberland Md.</u>			
				D. STREET ADDRESS (If rural, give location) <u>54 1/2 Marion Street</u>		<u>51-02</u>	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	White	Married	6-25-98	67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Salesman</u>		<u>Republic Powder Metals</u>		<u>Baltimore Md</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John M. Streett				Jessie Spicer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<u>yes</u> <u>WWI + WWII</u>						<u>Mrs. John J. Streett</u> <u>Cumb. Md</u>	
18. <u>148X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) <u>Rupture of Internal Carotid artery</u>			
ANTECEDENT CAUSES				(B) <u>Carcinoma of pharynx</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <u>Post radiation therapy</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>10/15/65</u>		<u>Ca of pharynx</u>		<u>Yes</u>		<u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <u>10/8/65</u> 19 <u>65</u> to <u>10/28</u> 19 <u>65</u> , that (we) last saw the deceased alive on <u>10/27</u> 19 <u>65</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
23A. SIGNATURE <u>HR Gertner, Jr.</u> M.D.				23B. DATE SIGNED <u>10/28/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>Harold R. Gertner Jr.</u> M.D.				23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/2/65</u>		<u>Arlington Natl Cem</u>		<u>Arlington Va</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11199				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11199	
M.E. CASE NO. Henry Hutton				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Henry E. Hutton				2. DATE AND HOUR OF DEATH Oct. 31, 1965 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2403			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Balto. Gen. Hosp.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1219 Battery Ave			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Feb. 4, 1884	9. AGE (In Years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner			10B. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Edward Hutton				14. MOTHER'S MAIDEN NAME Mary Reinicker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Margaret Michael 1420 Belt St.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Anteroseptal Cardiac Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malnutrition and Dehydration							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Calvin E. Jones, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/31/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 4 1965		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11200		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11200	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Agnes Kielian			2. DATE AND HOUR OF DEATH October 29, 65 345 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 521 S. Port St			A. STATE B. COUNTY 521 S Port St Baltimore Md F03		
5. SEX F			6. RACE W		7. MARRIED, NEVER MARRIED (Specify) WIDOWED, DIVORCED
8. DATE OF BIRTH 1890		9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME Giza		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Coronary Thrombosis (B) DUE TO Atherosclerotic Heart Disease (C)		INTERVAL BETWEEN ONSET AND DEATH Acute ?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 63 to Oct. 29, 19 65, that (I) (we) last saw the deceased alive on Oct. 27, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 345 Pm.					
23A. SIGNATURE Israel Feinglos M.D.				23B. DATE SIGNED 10/30/65	
23C. PHYSICIAN'S NAME (Type) ISRAEL J. FEINGLOS M.D.				23D. ADDRESS 2002 E. PRATT ST. Balt. 31 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-2-65		24C. NAME OF CEMETERY OR CREMATORY St Stanislaus	
24D. LOCATION (City, town, or county) Baltimore		24E. ADDRESS			
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Fred W. Ozajewski 1930 Eastern Ave	

James Thompson  
C. Thompson  
James

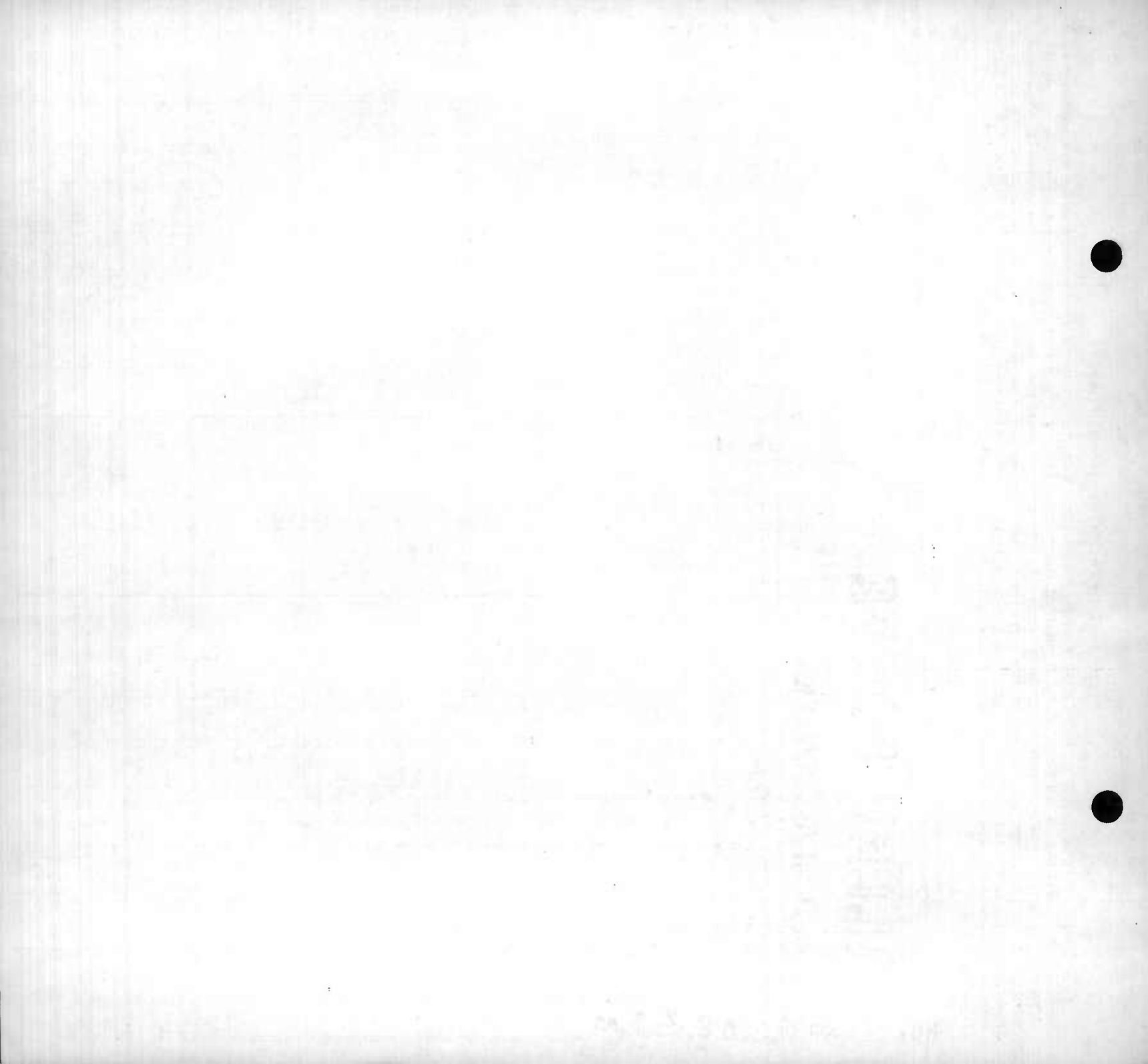
Oct. 11  
1891

James Thompson  
C. Thompson  
James

# FUNERAL DIRECTOR: IMPORTANT

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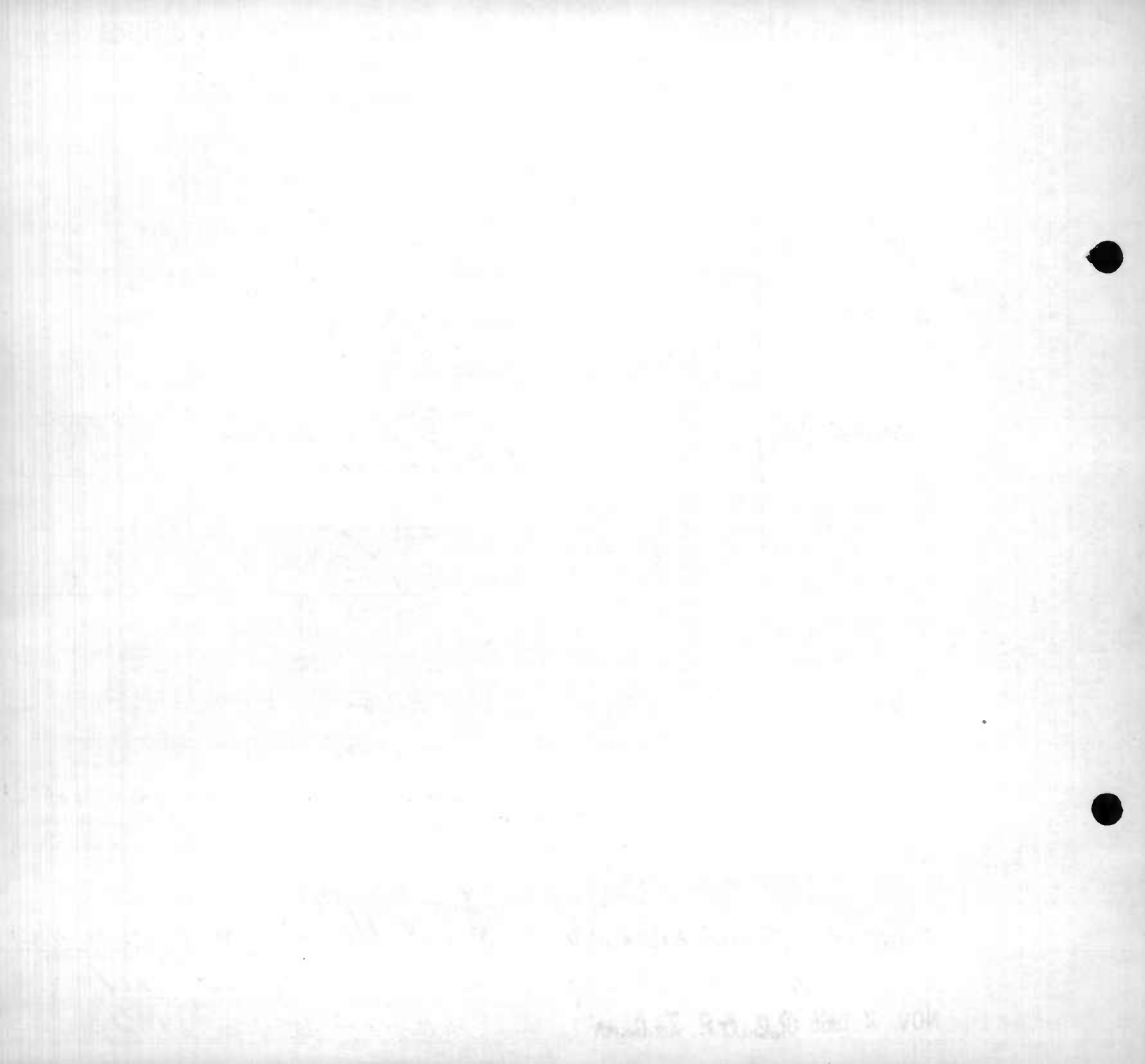
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 11201		CERTIFICATE OF DEATH				Registered No. 65 11201			
1. NAME OF DECEASED (Type or Print) Clarence G. Hammond					2. DATE AND HOUR OF DEATH Oct. 31, 1965 5:00 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 516 Cording Avenue Baltimore, Md. 21212					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-48 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 516 Cording Avenue				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Dec. 22, 1885	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George W. Hammond					14. MOTHER'S MAIDEN NAME Belle E. Price				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Margaret S. Hammond (Wife)		ADDRESS Same		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH Coronary Occlusion (A) DUE TO Generalized Arteriosclerosis (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from January 19 54 to Oct 31 19 65, that (I) (we) last saw the deceased alive on Oct 31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Charles E. Carr, Jr.					M. D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/1/65		
23C. PHYSICIAN'S NAME (Type) Charles E. Carr, Jr.					23D. ADDRESS 3900 N. Charles St.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 3, 1965		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Eugenia K. Seitz		ADDRESS 5209 York Road, Baltimore, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11202				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11202	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				EMMA M. Potee		10-29-65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)		A. STATE MD B. COUNTY 25-04	
3611 S. Hanover St.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BATO.	
5. SEX F				6. RACE White		D. STREET ADDRESS (If rural, give location)	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW				8. DATE OF BIRTH Feb 28, 1874		9. AGE (In years last birthday) 91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME John Mc Pherson				14. MOTHER'S MAIDEN NAME Violetta -		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Family	
18. 43-0.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Cardiac Failure Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(B) DUE TO			
(C) DUE TO							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb. 1951 to Jan 1965, that (I) (we) last saw the deceased alive on Jan 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Eugene Schmitz M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10-29-65	
23C. PHYSICIAN'S NAME (Type) EUGENE SCHNITZER M.D.				23D. ADDRESS 3904 S. Hanover St. Balto. 25, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-1-65		24C. NAME OF CEMETERY OR CREMATORY Cedar H. H. Cem		24D. LOCATION (City, town, or county) (State) Brooklyn 25 Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 237 Pootamac Ave	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Certificate of Death		Registered No. 65 11203	
BIRTH NO. 65 11203		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MOSES AMSTERDAM		2. DATE AND HOUR OF DEATH 10/30/65 6:12 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL				A. STATE MD. B. COUNTY BALT. 27-15			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT			
				D. STREET ADDRESS (If rural, give location) 6209 PIMLICO RD.			
5. SEX M.	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/17/1904	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEXTON		10B. KIND OF BUSINESS OR INDUSTRY SYNAGAGUE		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME DON GRIVA				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT HELENE AMSTERDAM 6209 PIMLICO RD			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) ACUTE MYOCARDIAL INFARCTION		36 HRS	
ANTECEDENT CAUSES				(B) ASCVD		UNKNOWN	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 10/29/65 1965 to 10/30 1965, that (I) (we) last saw the deceased alive on 10/30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stephen M. Kaplan M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10/30/65			
23C. PHYSICIAN'S NAME (Type) STEPHEN M. KAPLAN M.D.				23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Nov 1 1965		24C. NAME OF CEMETERY or CREMATORY CHEFRA AKAVAS CEM		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Jack Lewis Inc 2100 FULTON RD.			

For Office

No

CHAMBERLAIN

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RECEIVED  
JAN 10 1892  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

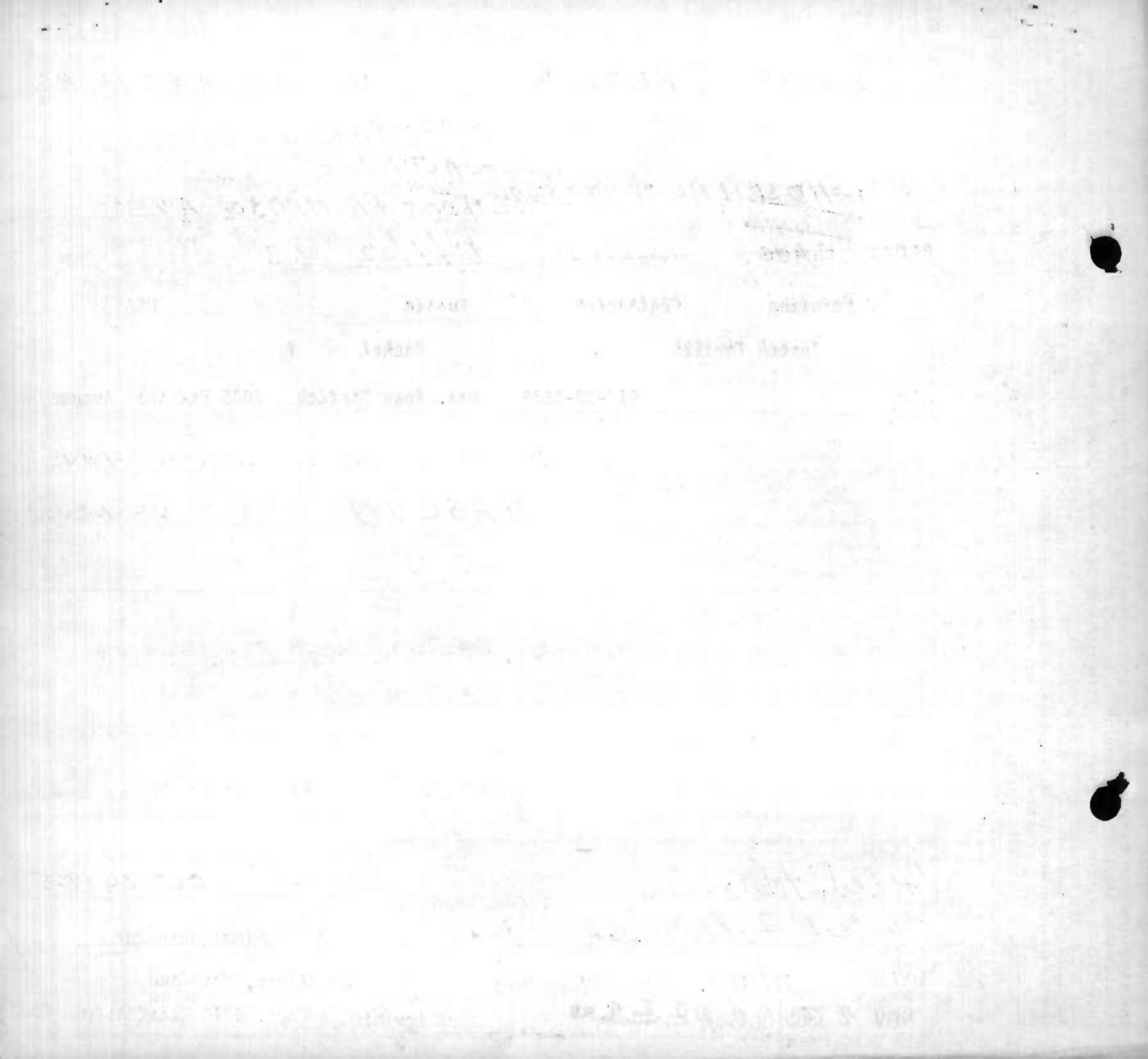
BALTIMORE CITY HEALTH DEPARTMENT													
65 11204						Certificate of Death		Registered No. 65 11204					
BIRTH NO.													
M.E. CASE NO.													
1. NAME OF DECEASED (Type or Print) <i>Brown, William Edward</i>						2. DATE AND HOUR OF DEATH <i>10/28/65 11:00 P.M.</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>A.A.</i>							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Montebello State Hospital</i>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Annapolis 32-10</i>							
						D. STREET ADDRESS (If usual, give location) <i>833 Spa Rd.</i>							
5. SEX <i>Q M</i>		6. RACE <i>C</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>3/10/85</i>		9. AGE (in years last birthday) <i>80</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ret. civil service</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>1</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>William H Brown</i>						14. MOTHER'S MAIDEN NAME <i>Julia Oonley</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-54-9310</i>		17. INFORMANT <i>ANNAPO LIS-Md Delia Brown 833 Spa Rd.</i>							
18. <i>144XH-260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes mellitus</i>						CAUSE OF DEATH (A) <i>cachexia</i> DUE TO (B) <i>carcinoma palato</i> DUE TO (C) _____						INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>No</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, loam, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>10/19 1965</i> to <i>10/28 1965</i> , that (I) <i>(we)</i> lost saw the deceased alive on <i>10/28 1965</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> (did not) view the body after death.													
23A. SIGNATURE <i>Robert W. Ireland</i> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>10/28/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>Robert W. Ireland</i> M.D.						23D. ADDRESS <i>Montebello State Hospital</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct. 31-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Brewer Hill</i>				24D. LOCATION (City, town, or county) (State) <i>Annapolis - Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 2 1965</i>				25B. NAME OF REGISTRAR <i>Robert E. Ireland</i>				25C. FUNERAL DIRECTOR <i>C. E. Hicks</i>				ADDRESS <i>Annapolis-Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				Registered No. <u>65 1120</u>	
BIRTH NO. <u>632 65 11205</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LOUIS TRETICK</u>	
2. DATE AND HOUR OF DEATH <u>OCTOBER 30 1965 10:10A.M.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL OF BALTIMORE</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-19</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>4005 PRIMROSE AVE.</u>		5. SEX <u>MALE</u> 6. RACE <u>CAUC</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>			
8. DATE OF BIRTH <u>10/4/02</u>		9. AGE (In years last birthday) <u>63</u>		If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painting</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Tretick</u>			
14. MOTHER'S MAIDEN NAME <u>Rachel ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>214-30-5539</u>		17. INFORMANT <u>Mrs. Rose Tretick</u> ADDRESS <u>4005 Primrose Avenue</u>			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCTION 4 HOURS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HASCVD</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>OCT 30 19 65</u> to <u>OCT 30 19 65</u> , that (I) (we) last saw the deceased alive on <u>OCT 30 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Herbert Fellerman</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>OCT. 30, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Herbert Fellerman</u>		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/31/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hebrew Young Mens</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fellerman</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. 6010 Reisterstown Road</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 11206		CERTIFICATE OF DEATH	
M.E. CASE NO.		65 11206			
1. NAME OF DECEASED (Type or Print)		Sidney Stollof		2. DATE AND HOUR OF DEATH October 28/65 2:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND		B. COUNTY 15-13	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 2814 OSWEGO AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/14/1918	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY FOOD FAIR		11. BIRTHPLACE (State or foreign country) CHICAGO, ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ROBERT MATTHEW STOEEOFRX		14. MOTHER'S MAIDEN NAME LEAH ROSENBERG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-09-0989		17. INFORMANT MRS. SYLVIA STOLLOF 2814 OSWEGO AVENUE	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH Sudden death		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Arterio-Sclerotic Heart Disease 5 years			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchial Asthma					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Feb. 1948 to October 28 1965, that (I) last saw the deceased alive on 10/23/65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the hospital) (did not) view the body after death.					
23A. SIGNATURE Julius C. Gluck		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/28/65	
23C. PHYSICIAN'S NAME (Type) Julius C. Gluck		M.D. 23D. ADDRESS 5356 Reisterstown Rd. Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/29/65		24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH BETH ISRAEL	
24D. LOCATION BALTIMORE MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD		ADDRESS			



Centre for the Study of the History of the

Arctic and Antarctic Regions

University of Cambridge

10/22/02

10/22/02

James C. Black

10/22/02

BIRTH NO. 65 11207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11207

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SAMUEL LEVIN

2. DATE AND HOUR PRONOUNCED DEAD

October 27, 1965 1:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

473 Arlington Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

473 Arlington Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

1894

9. AGE (In years  
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETAIL

10B. KIND OF BUSINESS OR INDUSTRY

SELF-EMPLOYED

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

EDWARD LEVIN

14. MOTHER'S MAIDEN NAME

BESSIE ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NO

17. INFORMANT

ADDRESS PHIL. PA.

STANLEY WISNOFF 3313 N BROAD ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 27, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

10/28/65

23C. NAME of CEMETERY or CREMATORY

Har Hebo

23D. LOCATION

(City, town, or county)

(State)

Philadelphia, Pa

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Sol Lenson, 2nd - 6010 Res. Rd.

ADDRESS

VALLEY  
FEDERAL  
POLICE

RECEIVED

1963  
NOV 11

TO DIRECTOR V. BICE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 11208		CERTIFICATE OF DEATH		65 11208	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HARRY BORENSTEIN, JR.		2. DATE AND HOUR OF DEATH OCTOBER 29, 1965 2:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3204 GARRISON BOULEVARD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3204 GARRISON BOULEVARD 2ND FLR			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME AARON HARRY BORENSTEIN			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. ESTHER SCHWARTZMAN 3204 GARRISON BLVD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ARTERIOSCLEROTIC HEART DUE TO DISEASE (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 12 YRS.	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC. 14, 1959 to OCT. 29, 1965, that (I) (we) last saw the deceased alive on OCT. 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin Goldstein				23B. DATE SIGNED 10/30/65	
23C. PHYSICIAN'S NAME (Type) DR. MARVIN GOLDSTEIN		23D. ADDRESS 5334 LIBERTY HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/31/65		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	
24D. LOCATION BALTIMORE		24E. LOCATION (City, town, or county) (State) MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	

15

452

5-10-81 287-3923-0-1A2825

11-5-54

10-27-83

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 11209					CERTIFICATE OF DEATH				
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
CELIA WACHS					10-30-65 4:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
HOUSE IN THE PINES-BELVEDERE					MARYLAND				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE				
					D. STREET ADDRESS (If rural, give location)				
					5106 QUEENSBURY ROAD				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
FEMALE		WHITE		MARRIED				71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				AT HOME		BALTIMORE, MARYLAND		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
WOLFE PAYMER					BLUMA PESKIND				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					216-22-4530		MR. HARRY WACHS 5703 CHILHAM ROAD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
170X 41 260X					Carcinoma of Breast				
ANTECEDENT CAUSES					(A) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					(C) DUE TO				
II					Diabetes Mellitus				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 7 1965 to 10-30-1965, that (I) (we) last saw the deceased alive on 10-30-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
JEROME COLLIER								10-30-65	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
					2217 South Rd Balto 9 Md				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		10/31/65		HEBREW YOUNG MENS		BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 2 1965		Robert E. Farkner		SOL LEVINSON & BROS. INC.		6010 REISTERSTOWN RD			

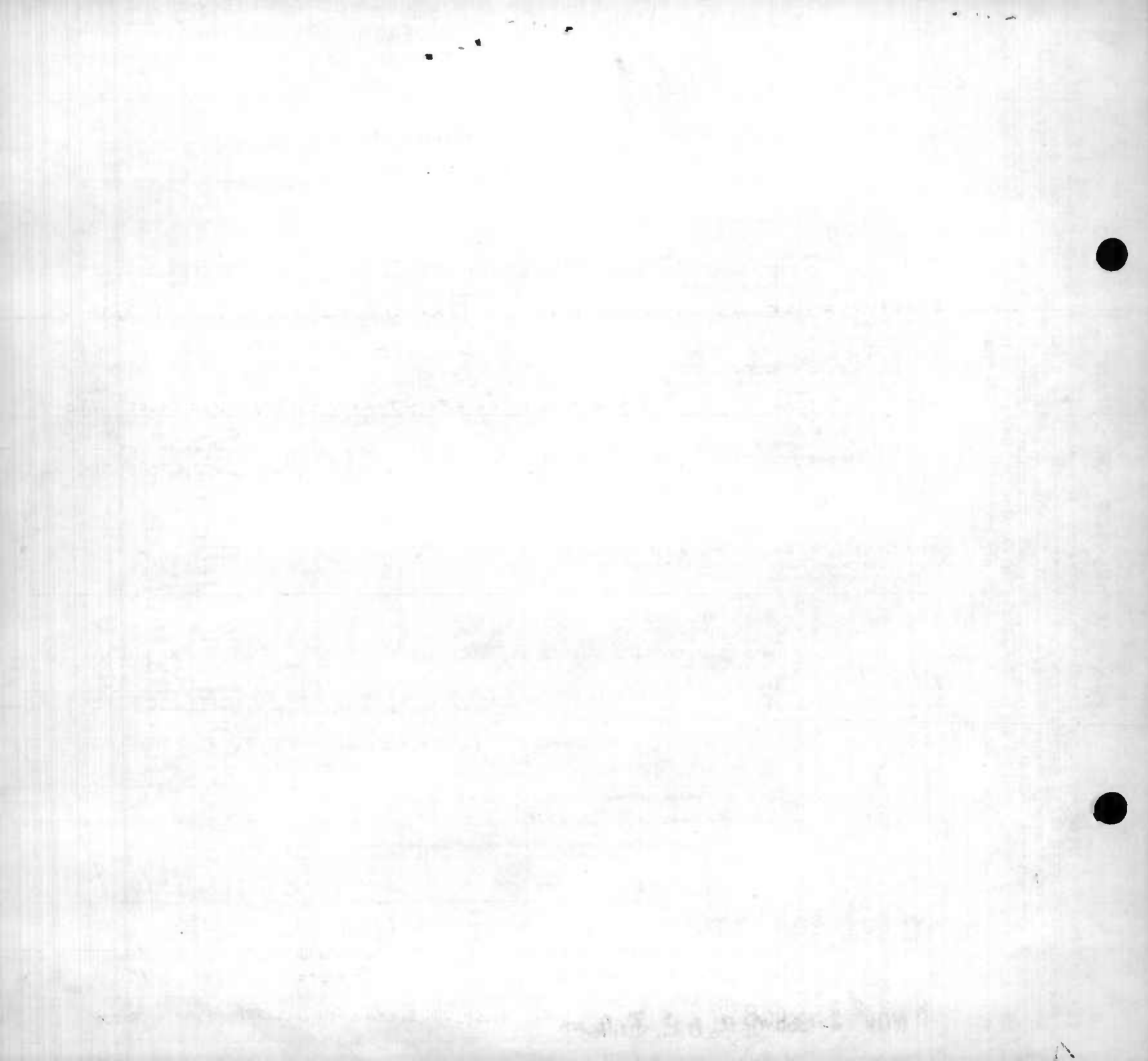




FUNERAL DIRECTOR: IMPORTANT

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65 11210		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11210	
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.				10/31/65 16:10 P M.	
1. NAME OF DECEASED (Type or Print) CLARENCE Edward Stoler					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION 12 SINAI HOSPITAL		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 3909 ROSECREST RD			
5. SEX MALE	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/7/22	9. AGE (In years last birthday) 43 yrs	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTROLOGIST		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HARRY		14. MOTHER'S MAIDEN NAME ANNIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES II		16. SOCIAL SECURITY NO. 214-03-0964	17. INFORMANT ADDRESS ALICE STOLER - 3909 ROSECREST RD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E951X1		CAUSE OF DEATH (A) Acute Yellow Atrophy DUE TO (B) Serum Hepatitis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH App. 7-10 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1/10/1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric Atony		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/1/65 to 10/31/65, that (I) (we) last saw the deceased alive on 10/31/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome Paul Reichmister		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/31/65	
23C. PHYSICIAN'S NAME (Type) Jerome Paul Reichmister		23D. ADDRESS Sinai Hosp. of Balto			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11/2/1965	24C. NAME OF CEMETERY or CREMATORY Windsor Mill Rd		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR SYLVANUS LEWIS & SON, INC. 3319 OLYMPIA AVE	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11211		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11211	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Elisha Midgette (Elijah)</i>		2. DATE AND HOUR OF DEATH <i>Nov 1, 1965 12:35 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital, Lombard + Greene Sts.</i>		A. STATE <i>Maryland</i> B. COUNTY <i>18-02</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>258 W. Arlington Ave.</i>			
5. SEX <i>M</i>	6. RACE <i>N.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Separated</i>	8. DATE OF BIRTH <i>3/15/99</i>	9. AGE (in years lost birthday) <i>66</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>N.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Charles Midgette</i>			14. MOTHER'S MAIDEN NAME <i>Hattie Mann</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or Unknown) (If yes, give war or dates of service) <i>Yes WWI</i>		16. SOCIAL SECURITY NO. <i>217-03-0618</i>		17. INFORMANT <i>David Midgette 1626 Post St.</i>	
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Cerebrovascular Hemorrhage</i> DUE TO (B) _____ DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <i>- 11 hours.</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(X)</i> (this hospital) attended the deceased from <i>Oct 31 1965</i> to <i>Nov 1 1965</i> , that <i>(X)</i> (we) last saw the deceased alive on <i>Oct 31 1965</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(X)</i> (We) (did not) view the body after death.					
23A. SIGNATURE <i>E. Ann Robinson</i>				23B. DATE SIGNED <i>Nov 1 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. ANN ROBINSON</i>		23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-4-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Balto. Natl. Cem.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 2 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>George A. Kline 1348 N. Calhoun St</i>	

Received of the Hon. Secy. of the Navy

for the sum of \$100.00

on account of the purchase of

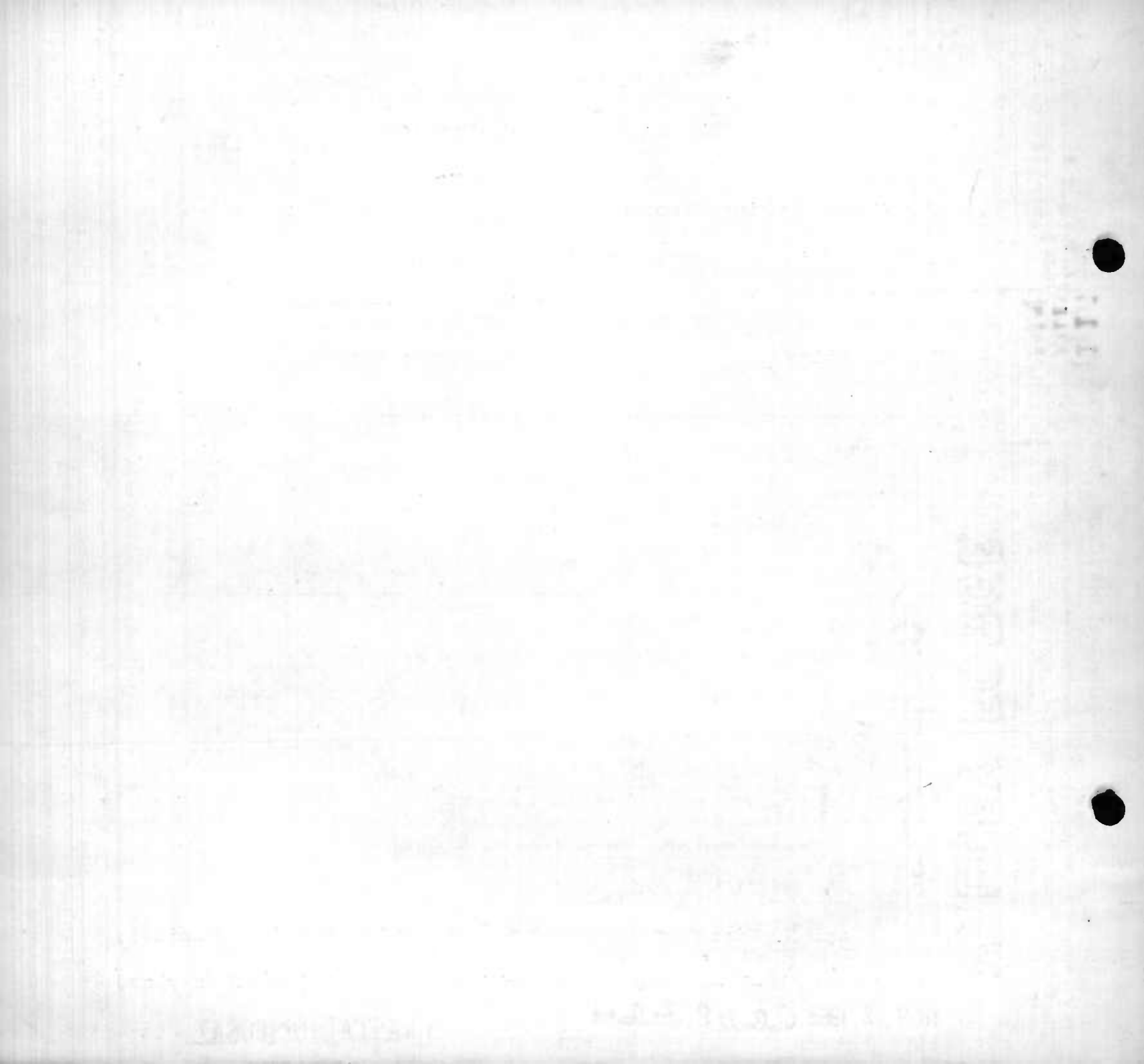
the sum of \$100.00

for the sum of \$100.00

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65-27155 65 11212				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11212	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Riley Baby Girl A.</i>				2. DATE AND HOUR OF DEATH 10-26-65 12: 40 p.m.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Johns Hopkins Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>44</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glen Burnie 5200</i> D. STREET ADDRESS (If rural, give location) <i>2103 Dorsey Road</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>10-26-65</i>		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: Hours: Min. <i>1</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Riley</i>				14. MOTHER'S MAIDEN NAME <i>Brenda Chaney</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. <i>773.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Hyaline membrane dis.</i> DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <i>11 hrs</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>26 October 1965</i> to <i>26 October 1965</i> , that (I) (we) last saw the deceased alive on <i>26 Oct 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Paul H. Visscher</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>26 Oct 65</i>					
23C. PHYSICIAN'S NAME (Type) <i>Paul H. Visscher</i>				23D. ADDRESS <i>The Johns Hopkins Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>cremation</i>		24B. DATE <i>10-31-65</i>		24C. NAME of CEMETERY or CREMATORY <i>The Johns Hopkins Hos.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE RECD BY HEALTH DEPT. <i>NOV 2 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>HOSPITAL DISPOSAL</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11213				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11213	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) Phillip Washington				10-28-65		112:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
90 Bar-Wil-Bq Convalescent Home				Md.		8-07	
5. SEX				6. DATE OF BIRTH		9. AGE (In years lost birthday)	
M.				1895		70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						Virginia	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown				Unknown		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						Mrs. Hilda Whittaker-1826 E. Biddle St.	
18. 450.0 I				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Generalized arteriosclerosis			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO			
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12-1-1961 to 10-26-1965, that (I) (we) last saw the deceased alive on 10-27-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
C.R. Campbell						10-28-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
C.R. Campbell				M.D. 1618 W. North Ave. Baltimore, Md. 21217			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11-3-65		Mt. Calvary Cemetery		Brooklyn, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 2 1965		Robert E. Fairbank		Charles A. Rice		661 W. Banne St	



May 2, 1911

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65-20339 <b>65 11214</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>65 11214</b>	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>TERRI L. JACKSON</b>		<b>10/31/65</b>		<b>1 104 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
<b>UNIVERSITY HOSPITAL</b>		<b>MD. 25-32</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		<b>BALTO.</b>			
		D. STREET ADDRESS (If rural, give location)			
		<b>2438 SEABURY AVE.</b>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
<b>F</b>	<b>N</b>	<b>INFANT</b>	<b>8-13-65</b>	<b>2</b>	<b>17</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				<b>BALTO.</b>	
12. CITIZEN OF WHAT COUNTRY?					
<b>USA</b>					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<b>ALPHONSE JACKSON</b>			<b>MARION WELLS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<b>NO</b>				<b>HOSPITAL CHART # 314925</b>	
18. <b>340.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		<b>CEREBRITIS + EDEMA ? 48 hr.</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		<b>BACTERIAL MENINGITIS</b>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<b>2</b>				<b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>10/30</b> 19 <b>5</b> to <b>10/31</b> 1965, that (X) (we) last saw the deceased alive on <b>10/31</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
<b>Albert M. Gordon</b>				<b>10/31/65</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<b>ALBERT M. GORDON</b>		<b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>	<b>11-3-65</b>	<b>St. Auburn Cemetery</b>		<b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>NOV 2 1965</b>		<b>Robert E. Jackson</b>		<b>Charles A. Rice, 661 W. Barre St.</b>	

1/46 - Processed 24 envelopes  
Letter from University of  
Iowa - Bur. of Botanicals - American  
Society

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

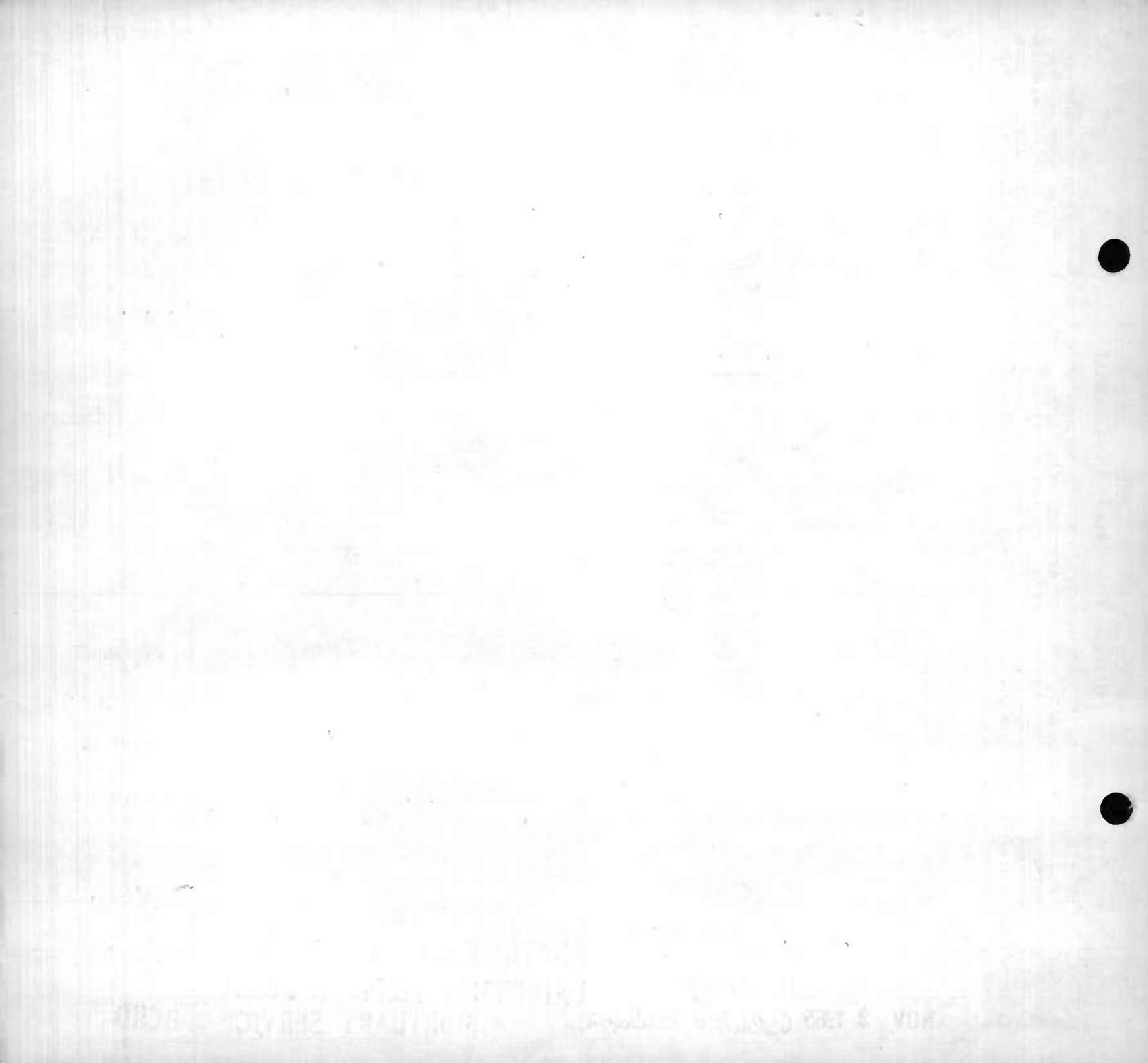
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11215</b>	
BIRTH NO. <b>65-24656 65 11215</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Baby of Lucy Smith</b>		<b>October 21, 1965</b> <span style="float: right;"><b>5:20 P M.</b></span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
10B. KIND OF BUSINESS OR INDUSTRY		D. STREET ADDRESS (If rural, give location) <b>8034 Norris Lane</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>10-20-65</b>
9. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. <b>776X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>IMMATUREITY</b> DUE TO (A) <b>IMMATUREITY</b> (B) DUE TO (C) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 20, 1965</b> to <b>October 21, 1965</b> , that (I) (we) last saw the deceased alive on <b>October 21, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Jose B. Covera, M.D.</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>October 22, 1965</b>
23C. PHYSICIAN'S NAME (Type) <b>Dr. Covera</b>		23D. ADDRESS <b>1514 Division Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>10-26-65</b>	
24C. NAME OF CEMETERY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>	
25C. FUNERAL DIRECTOR		ADDRESS	
<b>ANATOMY BOARD OF MARYLAND</b> <b>UNIVERSITY MEDICAL SCHOOL</b> <b>MORTUARY SERVICE - BCHD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

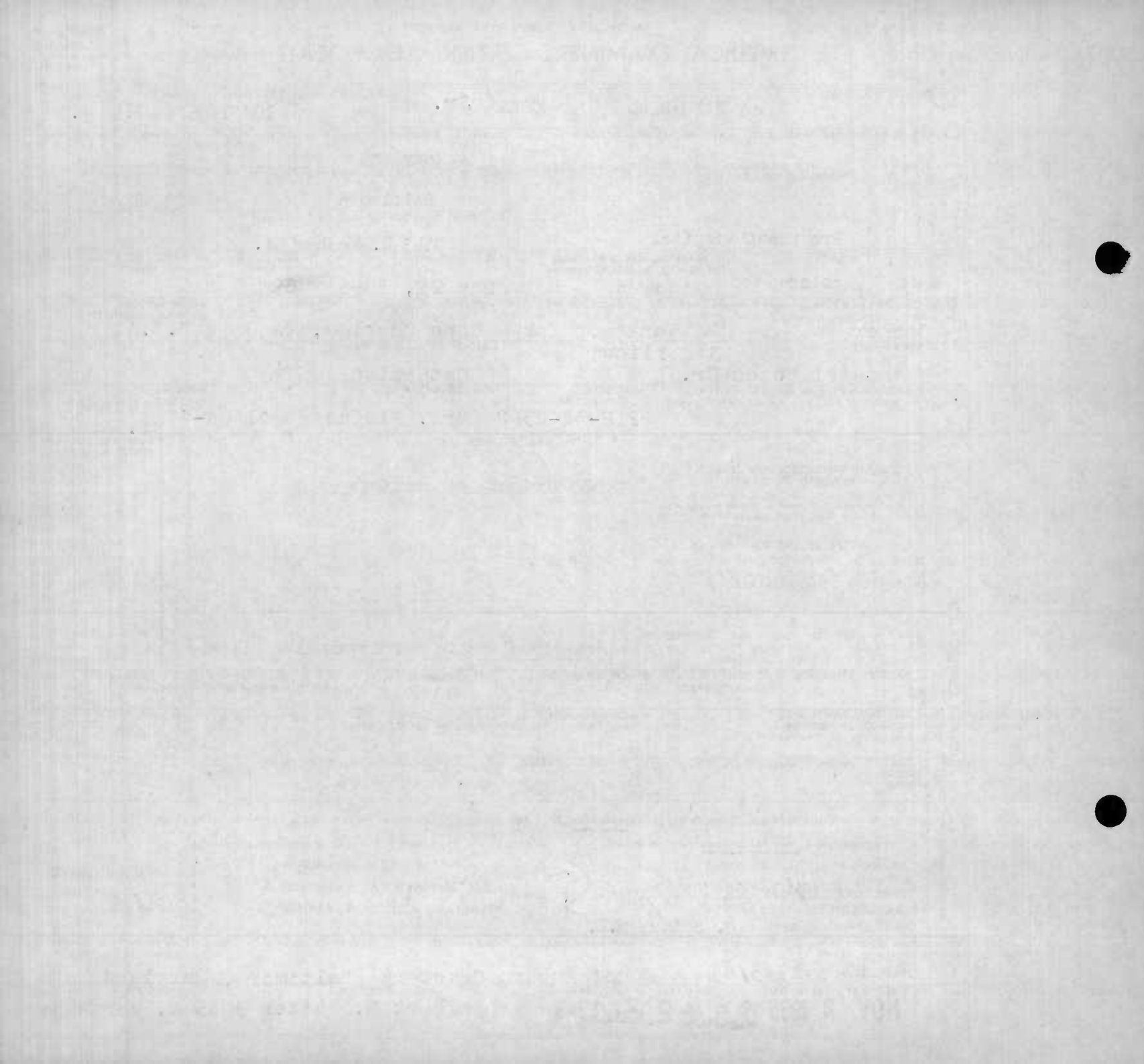
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11216	
BIRTH NO. 65 11216		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby of Josephine Walker</u>		2. DATE AND HOUR OF DEATH <u>October 20, 1965</u> <u>6:</u> <u>15</u> <u>11</u> <u>p.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>3253 Yosemite Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>October 11, 1965</u>	9. AGE (In years lost birthday) <u>9</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Howard Hammond, Jr.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>Josephine Walker</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>no</u>			17. INFORMANT <u>Josephine Walker-mother</u>		
			ADDRESS <u>same</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prematurity</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 11, 1965</u> to <u>October 20, 1965</u> , that (I) (we) lost saw the deceased alive on <u>October 20, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lionel C. Rose</u>				23B. DATE SIGNED <u>October 21, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lionel C. Rose</u>				23D. ADDRESS M.D. <u>1514 Division Street, Baltimore, Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>10-26-65</u>		24B. DATE <u>10-26-65</u>		24C. NAME OF CEMETERY <u>UNIVERSITY MEDICAL SCHOOL</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. CITY, TOWN, OR COUNTY <u>Baltimore</u>		24F. STATE <u>Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCD</u>	





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65 11217		BALTIMORE CITY HEALTH DEPARTMENT		65 11217	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		NATHANIAL MOSES Jr.		2. DATE AND HOUR PRONOUNCED DEAD 10/31/65 7:45 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
39 Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02			
D. STREET ADDRESS (If rural, give location) 543 W. Mosher St.					
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 29, 1896	9. AGE (In years last birthday) 69	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canner		10B. KIND OF BUSINESS OR INDUSTRY Md Workshop for the Blind		11. BIRTHPLACE (State or foreign country) Cape Charles, Va	
13. FATHER'S NAME Nathaniel Moses Sr.		12. CITIZEN OF WHAT COUNTRY? U.S.A			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-32-2362		17. INFORMANT Mrs. Elaine Hamilton-543 Mosher St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Carcinoma of prostate (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/31/65	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 11/5/65		23C. NAME of CEMETERY or CREMATORY Mount Auburn Cemetery	
24A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		24B. NAME OF REGISTRAR Robert E. Fairbank		24C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11218		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11218	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HALKER, HAROLD Gifford</b>		2. DATE AND HOUR OF DEATH <b>10/31 640 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-38</b> C. CITY OR TOWN (If outside city limits, write RURAL and give Township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1256 MERIDENE DRIVE</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	B. DATE OF BIRTH <b>11-6-17</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Sales</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Elwood Nebraska</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>HARRY Halker</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES TEWELL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WORLD WAR II</b>		16. SOCIAL SECURITY NO. <b>521-12-6022</b>		17. INFORMANT <b>BETTY L. HALKER 1256 MERIDENE DR</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>		CAUSE OF DEATH (A) <b>Myocardial Infarction</b> (B) <b>DUE TO</b> (C) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks + 1 day</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Oct. 31 1965</b> to <b>Oct 31 1965</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>Oct 31 19 65</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alex Silverman</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Oct 31, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALEX SILVERMAN</b>		23D. ADDRESS <b>6162 East Pratt St. Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov 4 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto National Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>The Dippel Brothers Inc. 7110 Belair Rd</b>	
25D. ADDRESS <b>21206</b>					

17

17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 11219		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11219	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Ella C. Ramming		2. DATE AND HOUR OF DEATH Oct. 28, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  90 Long Green Nursing Home		A. STATE Maryland B. COUNTY Baltimore (18) C. CITY OR TOWN (If outside city limits, write RURAL and give township) 647 Bartlett Ave. D. STREET ADDRESS (If rural, give location)			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Nov. 29, 1884	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Patrick Tully		14. MOTHER'S MAIDEN NAME Bridgett Cochran	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-8142		17. INFORMANT Arlington, Va. 22105 Mrs. John R. Harkins, 878 N. Kensington St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardiac Vascular Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from MAY 19 49 to Oct 28 1965, that (I) last saw the deceased alive on 10/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William H. Kammer, Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/1/65	
23C. PHYSICIAN'S NAME (Type) William H. Kammer, Jr.		23D. ADDRESS 6011 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/1965		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.	

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Wavelength 10000

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Wm H. K. K. K.

7-653

65 11220

BALTIMORE CITY HEALTH DEPARTMENT

65 11220

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BRUCE GEORGE THORNTON

2. DATE AND HOUR PRONOUNCED DEAD

10/28/65 3:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

811 Benninghaus Rd.

5. SEX  
male

6. RACE  
white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Never Married

8. DATE OF BIRTH

7/23/1949

9. AGE (In years  
last birthday) 16

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

School- Bly

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

George S. Thornton

14. MOTHER'S MAIDEN NAME

Genevieve M. Jankiewicz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

George S. Thornton (Same)

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH  
(A) Bilateral bronchopneumonia, complicating  
craniocerebral injury

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Paddington Rd. and Spring Lake Way

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

10 25 65 4:15p

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

operator of bicycle which collided with car

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/28/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

11/2/1965

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer

23D. LOCATION

Baltimore,

(City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1965

24B. NAME OF REGISTRAR

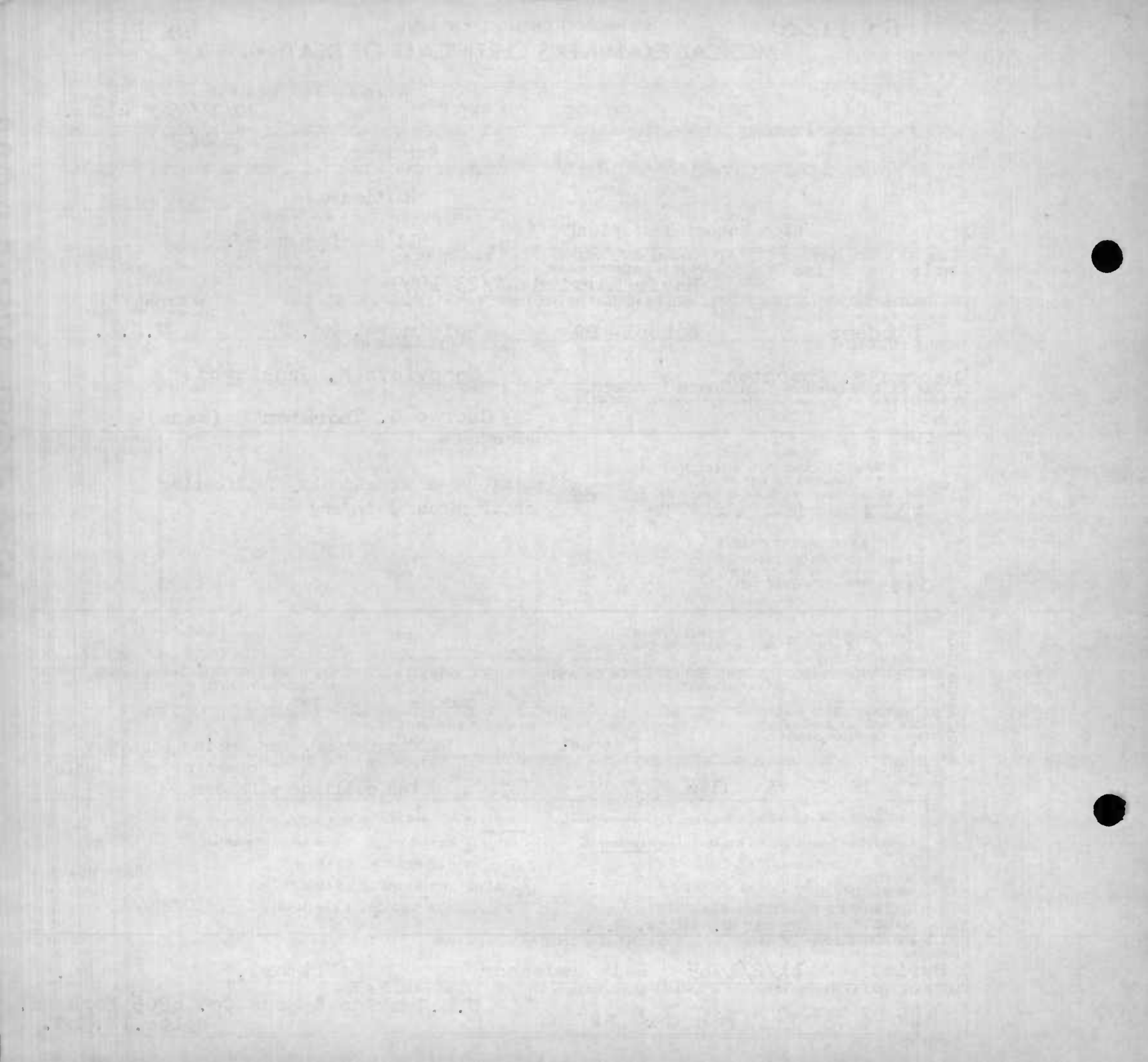
Robert E. Farber

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.

ADDRESS





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11221		CERTIFICATE OF DEATH		Registered No. 65 11221	
1. NAME OF DECEASED (Type or Print) <b>ORRICK, MARY TRACEY</b>				2. DATE AND HOUR OF DEATH <b>10/31/1965 1355 P. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSP</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>9-05</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>633 E 33RD ST.</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>7/18/05</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOCTY.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ATTORNEY</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>EDWARD TRACEY</b>				14. MOTHER'S MAIDEN NAME <b>AGNES MURRAY</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT ADDRESS <b>MRS. AGNES R. CONWAY, 2936 GLENVIEW ST. PHILADELPHIA 49, PA.</b>					
18. <b>163X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>CANCER OF LUNG</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>9/5/65 - 10/31/65</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>---</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>---</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>---</b>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>---</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>---</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>9/5</b> 19 <b>65</b> to <b>10/31</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10/31</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Charles S. Brown</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/31/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>CHARLES S. BROWN</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/4/1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>			

1985 3/10

1985 3/10

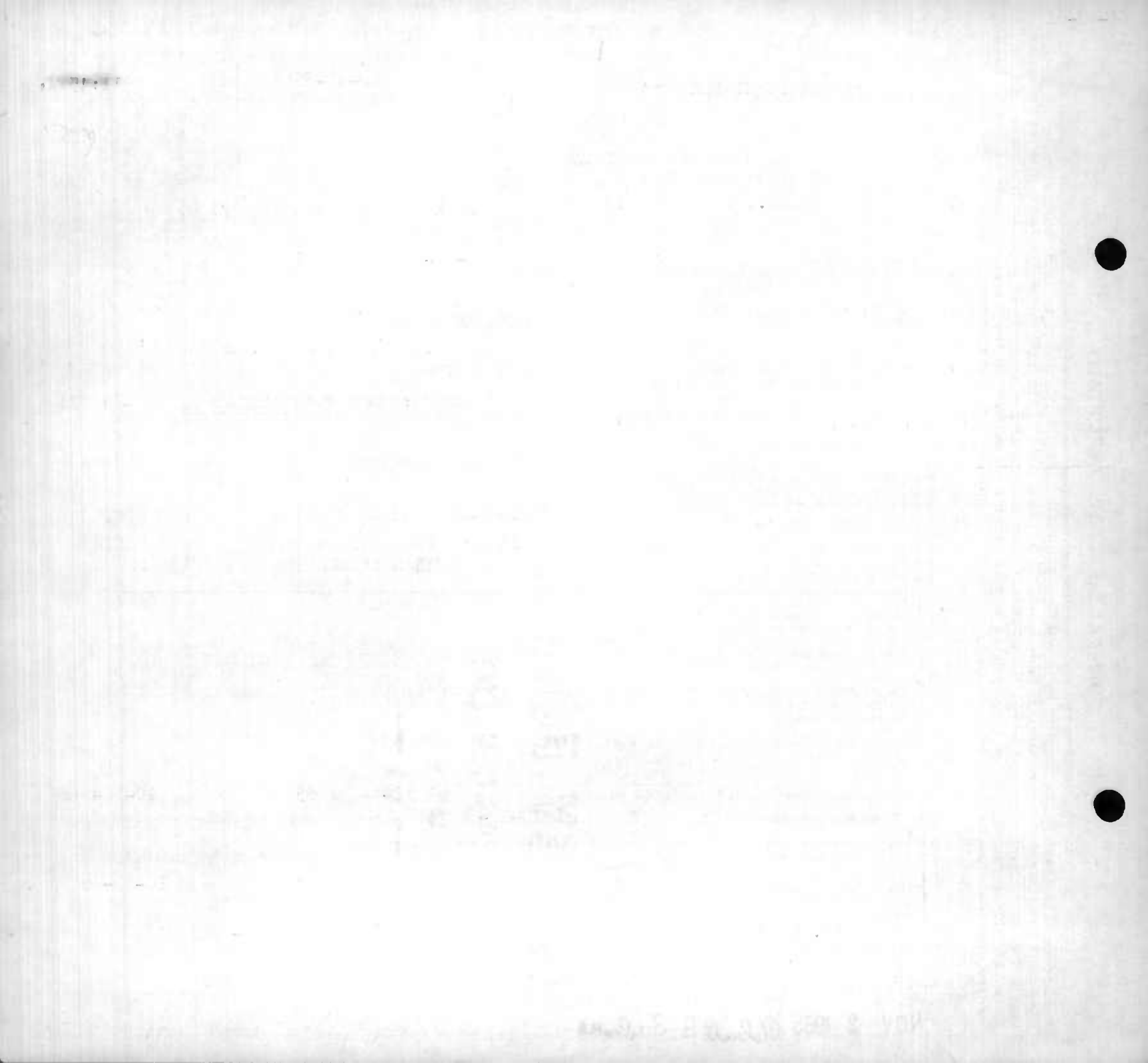
1985 3/10

1985 3/10

1985 3/10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

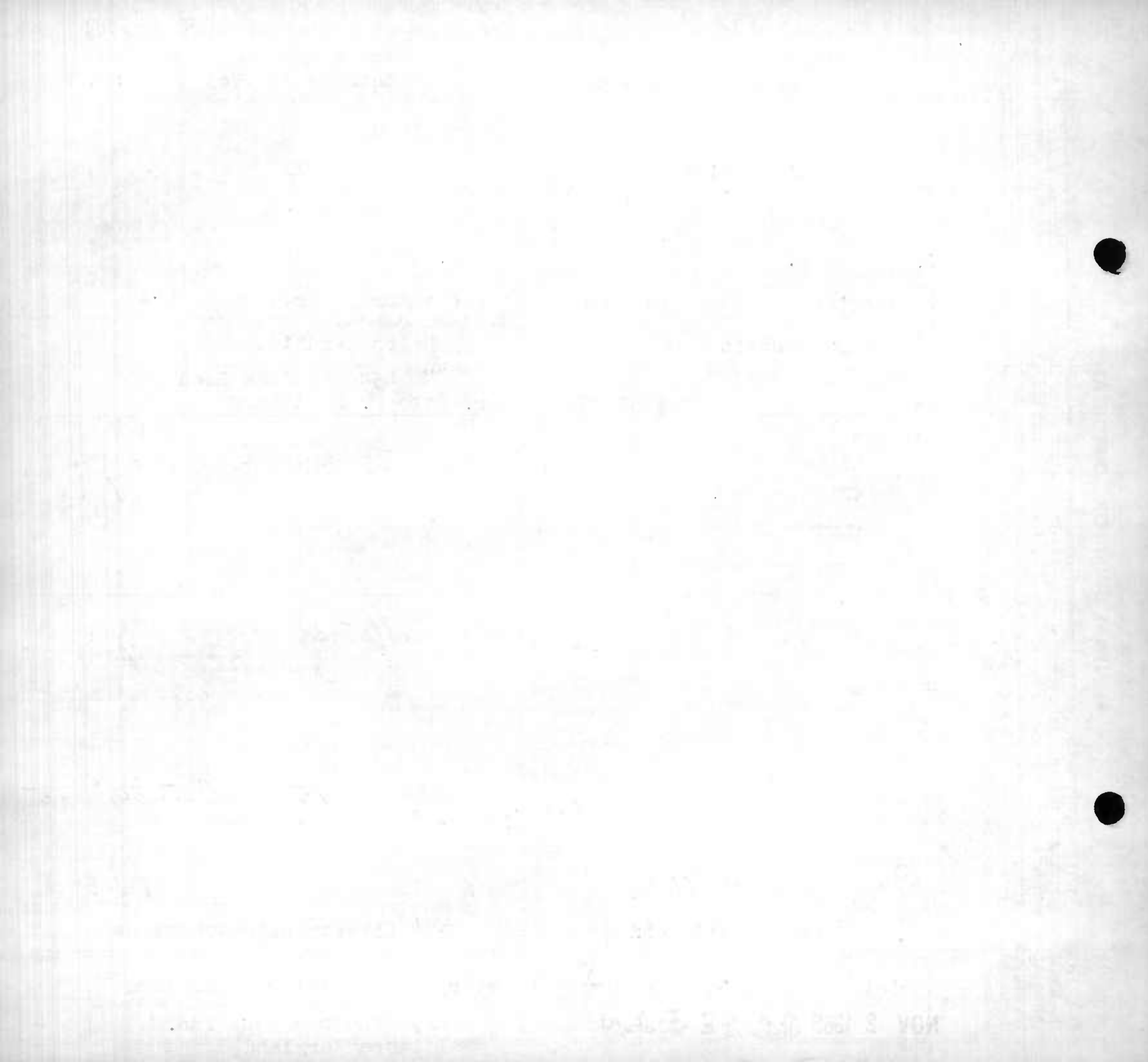
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11222	
BIRTH NO. 65 11222				CERTIFICATE OF DEATH	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ROBERT SCHRIEBER Se. HENRY				2. DATE AND HOUR OF DEATH 10-30-65 11:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO., MARYLAND 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
D. STREET ADDRESS (If rural, give location) 3021 McELDERY STREET #21205					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-28-02	9. AGE (in years last birthday) 63	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY PAINT CONTRACTING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT SCHRIEBER		14. MOTHER'S MAIDEN NAME GEORGIANA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE-#21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) CANCER OF ESOPHAGUS DUE TO (B) TRACHEO-ESOPHAGEAL FISTULA DUE TO ASPIRATION PNEUMONIA (C) CHRONIC ETHANAL INTAKE	
INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS 3 MONTHS 1 MONTH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-4-19 65 to 10-30-19 65, that (I) (we) last saw the deceased alive on 10-30-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Dean Albert M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10-30-65	
23C. PHYSICIAN'S NAME (Type) DR. HARRY DEAN ALBERT M.D.				23D. ADDRESS 4940 EASTERN AVENUE - #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-3-65		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM. BALTO., MD.	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Harry Dean Albert - 2334 Jefferson St. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 11223		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11223	
1. NAME OF DECEASED (Type or Print)				2. DAY AND HOUR OF DEATH					
Elizabeth Danneberg				October 30, 1965 6:30 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY					
Sinai Hospital				Maryland					
42				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				Baltimore 21211					
				D. STREET ADDRESS (If rural, give location)					
				4546 Keswick Road					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
F.	W.	Married	Aug. 2, 1889	76					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife			at Home		Baltimore, Maryland		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Henry Rehbein				Helen Barnhill					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			218 52 0788		4546 Keswick Road Mr. Otto F. Danneberg				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
420.0 260X				Arteriosclerotic Heart Dis.				10 yrs.	
ANTECEDENT CAUSES				(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II				Diabetes Mellitus				5 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from May 1965 to Oct. 30, 1965, that (I) (we) last saw the deceased alive on Oct. 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Marvin Goldstein				11/1/65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Marvin Goldstein				5334 Liberty Heights Avenue					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		11/2/65		Baltimore Cemetery		Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR				ADDRESS	
NOV 2 1965		Robert E. Taylor, M.D.		Henry Sander & Sons Inc.				Baltimore Maryland	





45-00-52  
JJ

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11224				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11224	
M.E. CASE NO.				CERTIFICATE AMENDED			
1. NAME OF DECEASED (Type or Print) <b>ALEXANDER FERGUSON</b>				2. DATE AND HOUR OF DEATH <b>10-29-65 1:55 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>11-03</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>417 W. BIDDLE STREET #21201</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED <del>WIDOWED</del> <b>MARRIED</b>	8. DATE OF BIRTH <b>5-17-08</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Ferguson</b>			14. MOTHER'S MAIDEN NAME <b>Betty</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-03-8515</b>		17. INFORMANT <b>RECORDS: BCH 4940 EASTERN AVENUE - #21224</b>			
18. <b>150X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <b>ASPIRATION PNEUMONITIS</b> DUE TO <b>TERMINAL CARCINOMA OF THE</b> (B) <b>ESOPHAGUS</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>6 MONTHS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-21-19 65</b> to <b>10-29-19 65</b> , that (I) (we) last saw the deceased alive on <b>10-29-19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. A. Dennis</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>10-29-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. M. A. DENNIS</b>				23D. ADDRESS <b>4940 EASTERN AVENUE - #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/4/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>A A Cemetery Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Adolphus Halstead 1206 W North Ave</b>			



65 11225

BALTIMORE CITY HEALTH DEPARTMENT

65 11225

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARY BACON

2. DATE AND HOUR PRONOUNCED DEAD

10/30/65 3:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY BaltoC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
Winter's Lane Extended

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Child

8. DATE OF BIRTH

10/11/56

9. AGE (in years  
last birthday)

9

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during part of working life, even if retired)

School

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Arnold Bacon

14. MOTHER'S MAIDEN NAME

Margaret Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Margaret Bacon Winters Lane Ex;

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gangrene of small bowel  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Volvulus  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/30/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/3/65

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

WALTER HODGE

HAS CONSENT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11226</b>	
BIRTH NO. <b>65 11226</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Ernest Piersanti</b>		2. DATE AND HOUR OF DEATH <b>Oct. 30, 1965 11:01 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>42 Sinai Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 15</b> D. STREET ADDRESS (If rural, give location) <b>2800 Manhattan Ave.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5/18/1904</b>
9. AGE (In years last birthday) <b>61</b>		10. IF Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Raphael Piersanti</b>	
14. MOTHER'S MAIDEN NAME <b>Elisa ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>212-20-6798</b>		17. INFORMANT <b>Mrs. Fernada G. Piersanti-2800 Manhattan Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <b>Coronary Artery Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
19A. DATE OF OPERATION <b>10/20/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/6 1961</b> to <b>10/30 1965</b> , that (I) (we) last saw the deceased alive on <b>10/26/65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>John R. Davis</b>		23B. DATE SIGNED <b>11/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN R. DAVIS</b>		23D. ADDRESS <b>401 Medical Arts Bldg. Balt. Md.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/2/65</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>4300 Old Frederick Rd. Balt. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>Loring Byers-8728 Liberty Rd. Randallstown</b>		25D. ADDRESS	

Private Property

Oct. 30, 1967

11:01

Bellevue

Bellevue 12

600 Harrison Ave.

Chief Hospital

2/14/1964

Private

White

1/14

U.S.A.

1-14

Don't believe

Factor

Medical Records

White

Bellevue 12

250-50-7000 Mrs. Patricia G. Harrison-2800 Harrison Ave.

401 Medical Arts Bldg. 1st Fl.

10th Fl.

1000 Old Federal Bldg. 1st Fl.

1st Fl. - Federal Library

11/1/67

Serial

1000 Old Federal Bldg. 1st Fl.

11/1/67

Serial



BIRTH NO.

65 11227

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 11227

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BENNETT ENGLISH

2. DATE AND HOUR PRONOUNCED DEAD

October 29, 1965

5:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Randallstown,

D. STREET ADDRESS (If rural, give location)

Green Lane

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

bus operator

10B. KIND OF BUSINESS OR INDUSTRY

Balto. Transit

11. BIRTHPLACE (State or foreign country)

Mardella, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Willard English

14. MOTHER'S MAIDEN NAME

Breitenacker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

215-09-3554

17. INFORMANT

ADDRESS

Ruth G. English, Greens La, Randallstown, Md

18.

431X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Ruptured dissecting aneurysm of aorta  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Hypertensive cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 29, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

23B. DATE

Nov. 1, 1965

23C. NAME of CEMETERY or CREMATORY

St. Jacobs Stone Ch

23D. LOCATION

(City, town, or county)

(State)

Cordorus, York Co. Pa.

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Loving

yers,

8728 Liberty Rd.

Liberty Rd.

Randallstown



USA

Washington, D.C.

John F. Kennedy

President

Executive Order

11358

John F. Kennedy, President of the United States

NO

John F. Kennedy, President of the United States

Nov. 1, 1962

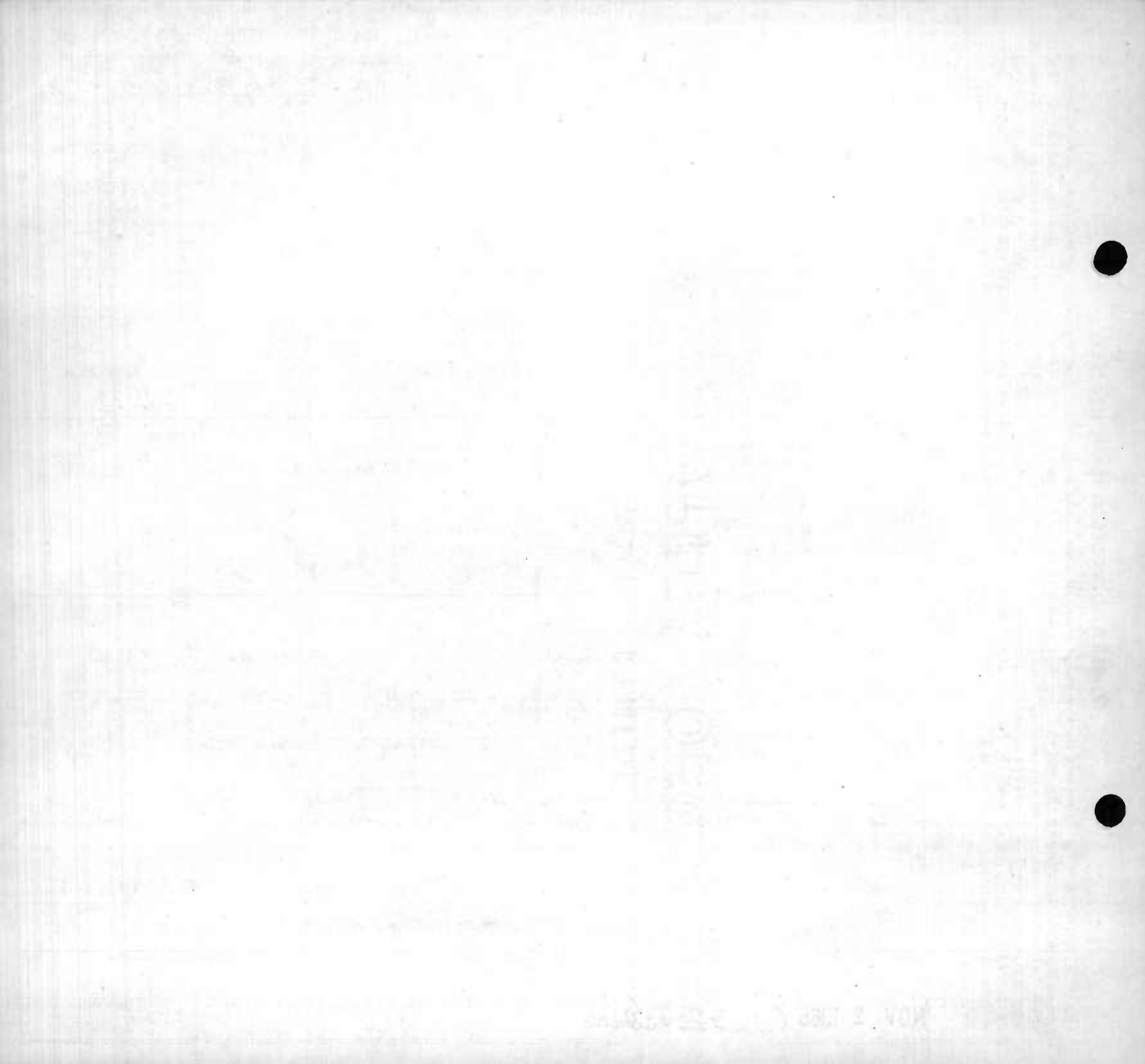
11358

John F. Kennedy, President of the United States

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

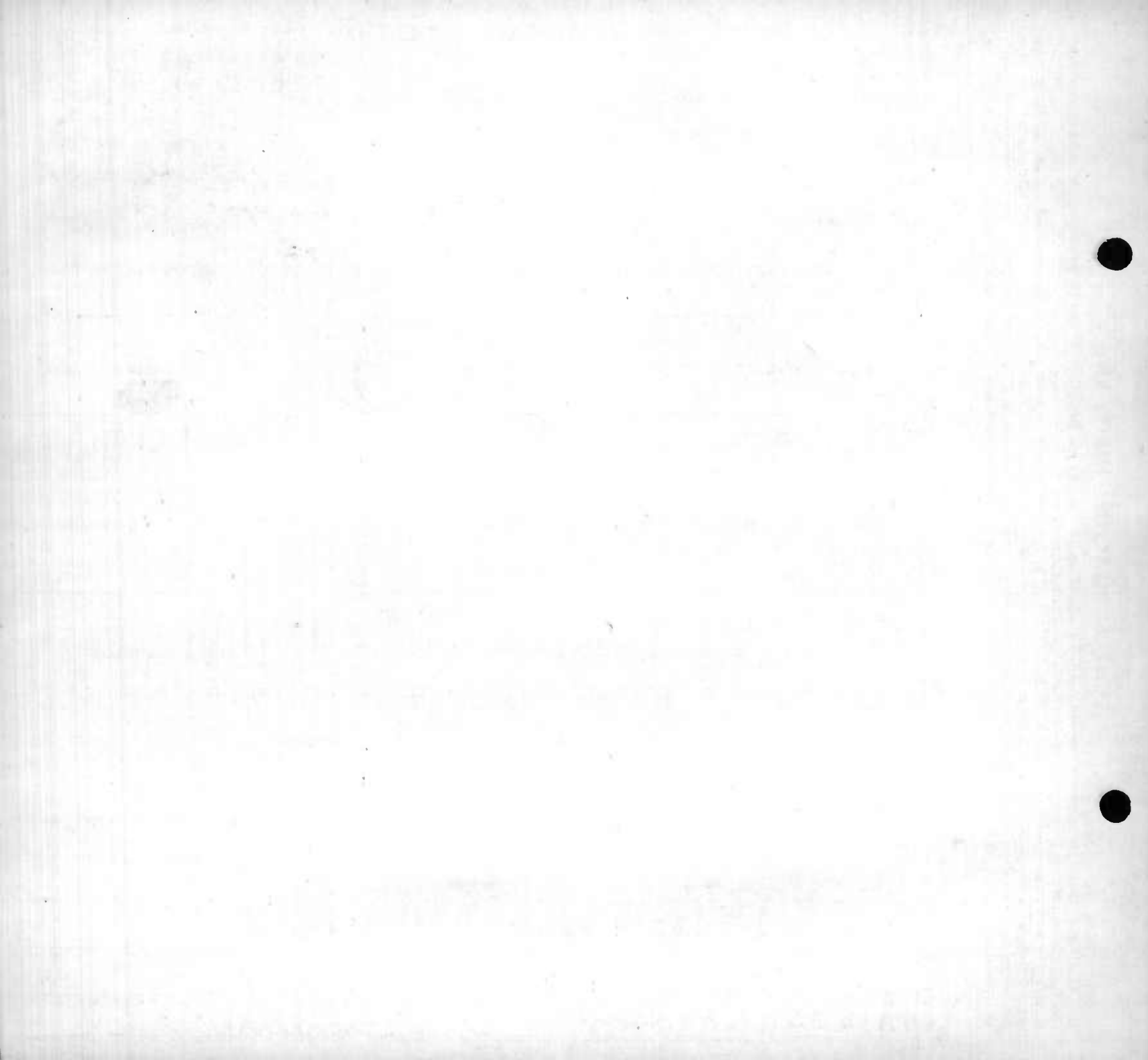
BIRTH NO. 65 11228		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11228	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>ROSE M. BURNS</i>			2. DATE AND HOUR OF DEATH <i>OCT. 31, 1965 10:45 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mount Convalescent Home 3706 Norton Rd. Baltimore, Md.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>A.A.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto 52-00</i> D. STREET ADDRESS (If rural, give location) <i>522 Sylvan Dr.</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>S</i>	8. DATE OF BIRTH <i>May 29, 1895</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
13. FATHER'S NAME <i>Edgar Burns</i>			14. MOTHER'S MAIDEN NAME <i>Blanche Crawford</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i> ADDRESS <i>Same</i>	
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Arteriosclerotic heart disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Sept. 22, 1961</i> to <i>Oct. 31, 1965</i> , that (I) ( <del>was</del> ) lost saw the deceased alive on <i>Oct. 28, 1965</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <i>Abraham B. Hurwitz</i> M.D.			23B. DATE SIGNED <i>Oct. 31, 1965</i>		
23C. PHYSICIAN'S NAME (Type) <i>ABRAHAM B. HURWITZ</i> M.D.			23D. ADDRESS <i>7501 LIBERTY ROAD, BALTIMORE, MD.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-3-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Damascus Com.</i>	
24D. LOCATION (City, town, or county) (State) <i>Damascus, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 2 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fink</i>	
25C. FUNERAL DIRECTOR <i>McCully, Sarah Ann</i>		25D. ADDRESS <i>237 Catapogues</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

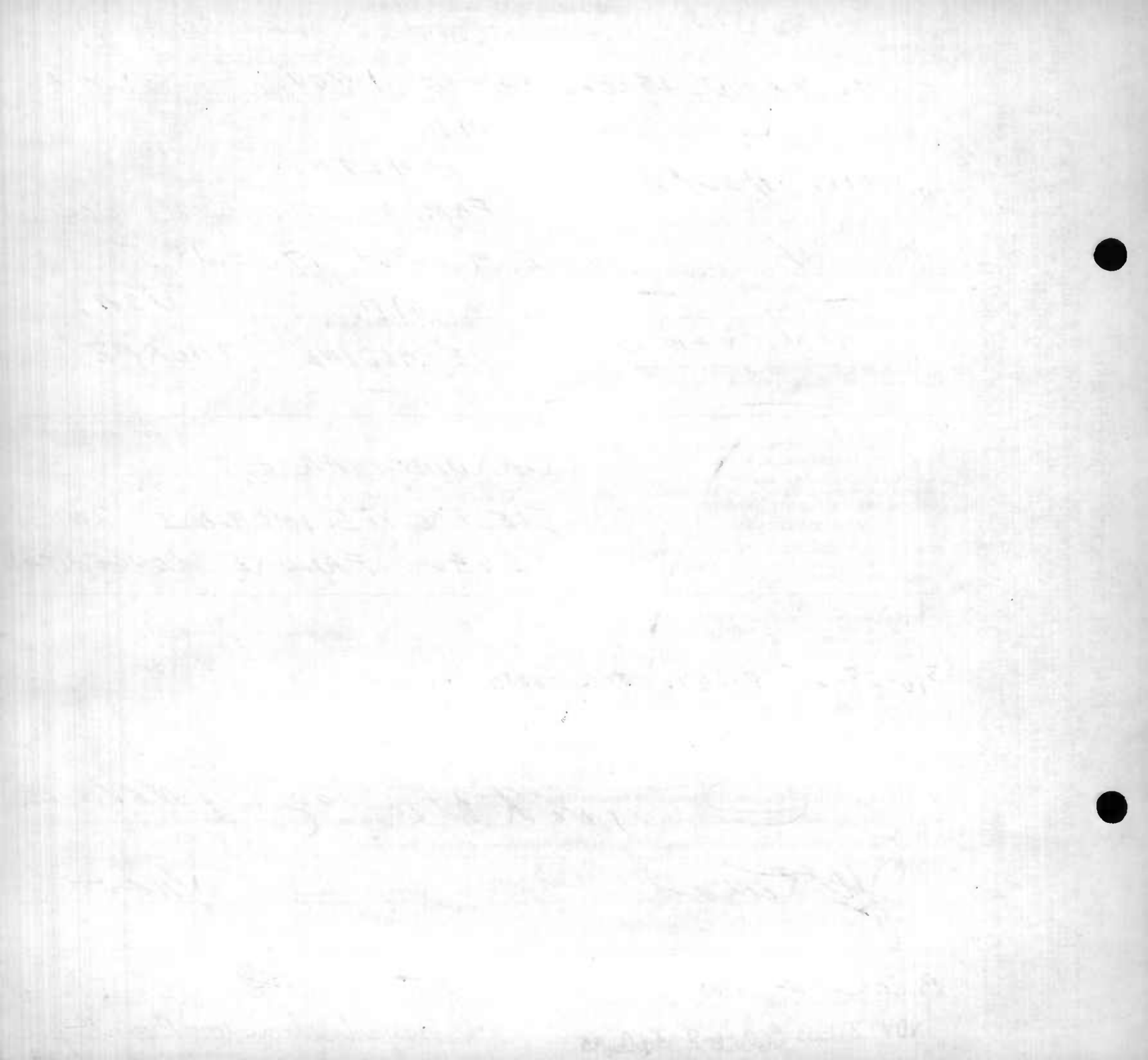
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 11229</u>	
BIRTH NO. <u>65 11229</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>HARRY E. HARPER</u>		2. DATE AND HOUR OF DEATH <u>2:58 10-30-65</u> <span style="float: right;">M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u> <span style="font-size: small;">(If not in hospital or institution, give street address or location)</span>		A. STATE <u>Maryland</u>			
		B. COUNTY <u>25-04</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>4115 - Townsend Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/18/01</u>	9. AGE (In years lost birthday) <u>63</u>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel mill</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>—</u>			14. MOTHER'S MAIDEN NAME <u>Mame —</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>	
				ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>420.141260X</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <u>Myocardial Infarction</u>		<u>2 days</u>	
		(B) DUE TO <u>Coronary Artery Disease</u>		<u>years?</u>	
		(C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Diabetes Mellitus</u>			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>October 29, 1965</u> to <u>October 30, 1965</u> , that (I) (we) last saw the deceased alive on <u>October 30, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert C. Blackmon</u>				23B. DATE SIGNED <u>10/30/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert C. Blackmon</u>				23D. ADDRESS <u>Lutheran Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-3-65</u>	24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cem</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>	25C. FUNERAL DIRECTOR <u>McDuffy, Frank the 2370 Pot. Ave.</u>		



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>65 11230</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 11230</u>	
M.E. CASE NO.		THORPE, HOWARD 17 MOS		5B	
1. NAME OF DECEASED (Type or Print) <u>HOWARD LEROY THORPE</u>		2. DATE AND HOUR OF DEATH <u>1 NOV. 8:20 A. M.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>UNIV. HOSP.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV. HOSP.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>63-51</u>		5. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO. 2722 Bookert Drive</u>	
6. RACE <u>N</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>4-26-64</u>	
9. SEX <u>M</u>		10. AGE (In years last birthday) <u>18 MOS.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>GERALDINE THORPE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <u>601X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>CARDIAC ARREST</u> DUE TO (B) <u>ELECTROLYTE IMBALANCE 2WKS.</u> DUE TO (C) <u>RENAL FAILURE CONGENITAL</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>10-28-65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BILAT. HYPONEPHROS.</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-24-65</u> to <u>1 NOV. 1965</u> , that (I) (we) last saw the deceased alive on <u>1 NOV. 1965</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>1 Nov.</u>		23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTO.</u>	
24D. LOCATION <u>BALTO.</u>		24E. ADDRESS <u>[Signature]</u>		24F. ADDRESS <u>[Signature]</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1965</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>	
25D. ADDRESS <u>[Signature]</u>		25E. ADDRESS <u>[Signature]</u>		25F. ADDRESS <u>[Signature]</u>	





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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 11231		<b>CERTIFICATE OF DEATH</b>		65 11231	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>FLEET, GLADYS</b>			2. DATE AND HOUR OF DEATH <b>10/26 9:15 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 University Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>25-33</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2404 Puget St.</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-6-32</b>	9. AGE (In years last birthday) <b>33</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US A</b>		13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Jones</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Husband - CARL FLEET</b> ADDRESS <b>2404 Puget St.</b>	
18. <b>410X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic Heart Disease &amp; Mitral Stenosis</b> DUE TO <b>Essential Vascular Hypertension</b> DUE TO (C) _____		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>1 A.M. 10-26-1965</b> to <b>9:15 A.M. 10-26-1965</b> , that (I) (we) last saw the deceased alive on <b>10-26-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Zalman S. Agus</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/26/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>ZALMAN S. Agus</b>		M.D. <b>University Hospital</b>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-29-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat. Cent</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>Choy Wilson - 1000 Brantley Ave</b>		ADDRESS			

RECEIVED  
BUREAU  
JAN 27 1933  
1-27-33

RECEIVED  
BUREAU  
JAN 27 1933  
1-27-33

RECEIVED - CIVIL DIVISION  
JAN 27 1933

10/20/32

RECEIVED

RECEIVED

NOV 2 1932

BIRTH NO. 65 11232		BALTIMORE CITY HEALTH DEPARTMENT		65 11232	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
JOHN W. CAGLER			10/27/65 7:45 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Maryland		
41 St. Joseph Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1319 N. Eden St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
male	colored		August 14	48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joe Cagler			Lula Bowre		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
no					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
422.1 I			Arteriosclerotic cardiovascular disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Cirrhosis of liver		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		10/28/65	
Wenner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Buried		11-2-1965		Mt. Airy	
		23D. LOCATION (City, town, or county)		(State)	
		Brooklyn		MD	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
NOV 2 1965		Robert E. Farber, M.D.		Chapman Wilson 1000 Brantley Ave	

1251

UNITED STATES OF AMERICA

1251

UNITED STATES OF AMERICA  
1251

BIRTH NO.

65 11233

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11233

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EUGENE BLUE

2. DATE AND HOUR PRONOUNCED DEAD

October 26, 1965 10:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

123 N. Carrollton Ave.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

7-6-1905

9. AGE (in years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George W. Blue

14. MOTHER'S MAIDEN NAME

Laura L Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Lucia Kent

ADDRESS

18.

163X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Carcinoma of the lung

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Oct. 27, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-1-1965

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1965

24B. NAME OF REGISTRAR

Robert E. Farker, M.D.

24C. FUNERAL DIRECTOR

Choy Wilson &amp; Co. Brantley Ave.

ADDRESS

7-1-1908

Letter to  
James & Henry  
from Bob

My  
dear  
James & Henry

James & Henry  
7-1-1908



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11234		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11234	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Spottswoot, Mabel		2. DATE AND HOUR OF DEATH October 27, 1965 8:55 P.M. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2444 N. McCulloh Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6-4-04	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Cerebro-vascular Accident Hypertension ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH Cerebro-vascular Accident Hypertension		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-27-65 19 65 to 10-27- 19 65, that (I) (we) last saw the deceased alive on 10-27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Rigaud		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/27/65	
23C. PHYSICIAN'S NAME (Type) A. Rigaud		23D. ADDRESS 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Paltimore Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 2 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR E. O. Wilson - 1000 Bantley St.			



Domestic Work

RECEIVED

10-27-82

10-27-82

10-27-82

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 11235	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 65 11235	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
ORA MAE PARKER			10/28/65 4:40 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland B. COUNTY		
41 St. Joseph Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01		
D. STREET ADDRESS (If rural, give location) 730 Mura St.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
female	colored	Married	March 13-19	36	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Darlington South Carolina U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Clay Horne			Bernice Samuels		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				William C Parker Same	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
(A) Undetermined at autopsy and upon microscopic examination					
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
Werner U. Spitz				10/28/65	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER			
Werner U. Spitz, M.D.					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		11-2-1965		Baltimore	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
NOV 2 1965		Robert E. Fink		Calroy O. Wilson 1000 Brantley	

WALTER DODGE

CHIEF OF BUREAU

U. S. DEPT. OF AGRICULTURE

Wm. H. Henshaw  
Director of the  
Bureau of Plant Industry  
Washington, D. C.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed purchase of the land in the State of California, and to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,  
Walter Dodge

65 11236 BALTIMORE CITY HEALTH DEPARTMENT 65 11236

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JOSEPH LAMMA (LAMMAN) 2. DATE AND HOUR PRONOUNCED DEAD 10/29/65 5:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 11-16-65 Hopkins Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-08 D. STREET ADDRESS (If rural, give location) 733 Bartlett Ave.

5. SEX male 6. RACE colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed 8. DATE OF BIRTH June 10, 1898 9. AGE (In years lost birthday) 67 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 11. BIRTHPLACE (State or foreign country) Balto. Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Lamman 14. MOTHER'S MAIDEN NAME Florence Watts 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) WWII yes 16. SOCIAL SECURITY NO. 17. INFORMANT Goldie Washington ADDRESS

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO  
ANTECEDENT CAUSES (B) DUE TO  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER [ ] DATE SIGNED 10/30/65  
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER [X]  
ASSOCIATE MEDICAL EXAMINER [ ]

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 11-19-65 23C. NAME OF CEMETERY or CREMATORY Balto Nat Cent 23D. LOCATION (City, town, or county) (State) Balto. Md.

24A. DATE REC'D BY HEALTH DEPT. NOV 2 1965 24B. NAME OF REGISTRAR Robert E. Finkenauer 24C. FUNERAL DIRECTOR E.O. Wilam 24D. ADDRESS 1000 Brantley Ave

vs 153 signed by funeral director. 11-16-65 cpb

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11237		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11237	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Lottie, Smith (Ringgold)</u>			2. DATE AND HOUR OF DEATH <u>10/30/65</u>   <u>3:30</u> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident, Hospital Inc.</u> <u>1514 Division St.</u> <u>Baltimore, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> , B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1403</u> <u>1925 Penna. Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>7/19/01</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry Ringgold</u>			14. MOTHER'S MAIDEN NAME <u>Susie Brown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Walter, Smith (son) 3400 Walbrook Ave.</u>
18. <u>331X 1260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetic Mellitus</u>			CAUSE OF DEATH (A) <u>Cerebral Hemorrhage</u> DUE TO (B) <u>Hypertension and Arteriosclerotic</u> DUE TO (C) <u>Vascular disease</u>  INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/26</u> 19 <u>65</u> to <u>10/30</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>10/30</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/30/65</u>
23C. PHYSICIAN'S NAME (Type) <u>Andrew, Riggs</u>			23D. ADDRESS M.D. <u>1514 Division St.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. CALVARY CEM.</u>	
24D. LOCATION <u>Brooklyn Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Chas. Wilson 1100 Brantley Ave.</u>			

DISPATCH

Enclosed

Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

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Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

Letter to Mr. Zeller, dated 12/1/50

NOV 2 1950



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11238				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11238	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)				BUTTA, JOSEPH LEO		OCTOBER 30, 1965 12:30am	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
44 Union Memorial Hospital				Baltimore		D. STREET ADDRESS (If rural, give location)	
4338 Sheldon Avenue 21206				5. SEX		6. RACE	
male				white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
widowed				8. DATE OF BIRTH		9. AGE (In years lost birthday)	
9/16/92				73 yrs.		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Metal Melter (Ret.)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
A.S. Abell & Co.				Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.				13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Butta				Lucille Ameche		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
no				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
213-03-2503				Leonard F. Butta, above		18. CAUSE OF DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		INTERVAL BETWEEN ONSET AND DEATH	
443X I				CAUSE OF DEATH		Interval between onset and death	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		Interval between onset and death	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		Interval between onset and death	
II				CAUSE OF DEATH		Interval between onset and death	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH		Interval between onset and death	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1950 to October 21 1965, that (I) (we) last saw the deceased alive on October 21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.	
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Dr. Melvin F. Polek				11/1/65		23D. ADDRESS	
3603 Belair Road				24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial				11/2/65		24C. NAME OF CEMETERY or CREMATORY	
Holy Redeemer Cemetery				Baltimore, Md.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 3 1965				Robert E. Fickens		Schimunek Funeral Home, Inc. 3331 Brehms Lane #13	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO. 65 11239

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANDREW J. NOVAK

2. DATE AND HOUR PRONOUNCED DEAD

10-31-65

5:32 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

817 N. Belnord Avenue 21205

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12/12/86

9. AGE (In years  
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Plumber

10B. KIND OF BUSINESS OR INDUSTRY

Novak &amp; Co. Builders

Baltimore

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Joseph Novak

14. MOTHER'S MAIDEN NAME

Katherine

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WWI

16. SOCIAL  
SECURITY NO.

216-10-9356

17. INFORMANT

ADDRESS

Frances Novak, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Partial

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-1-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/4/65

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 3 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

2601-03-05 E. Madison Street #5

WALTER FORCE

CHIEF OF POLICE

1911 - 1912

1911 - 1912

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11240</b>	
BIRTH NO. <b>65 11240</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SMITH, DELIA A.</b>		2. DATE AND HOUR OF DEATH <b>October 30, 1965   3:45P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3051 Mayfield Avenue Baltimore, Maryland 21213</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3051 Mayfield Avenue 21213</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>3/13/72</b>	9. AGE (In years last birthday) <b>93</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Smith</b>			
14. MOTHER'S MAIDEN NAME <b>Ann ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Ethel S. Shepard, Above</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.01 Antimicrobial Heart Dis.</b>		CAUSE OF DEATH <b>Antimicrobial Heart Dis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
19. DISEASE OR CONDITION CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 10 1945</b> to <b>Oct 30 1965</b> , that (I) (we) last saw the deceased alive on <b>Oct 29 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George Sawyer</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. George J. Sawyer Jr.</b>		23D. ADDRESS <b>4808 Harford Road</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/3/65</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 3 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane #13</b>			

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BIRTH NO. 65 11241 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE W. FOOTE

2. DATE AND HOUR PRONOUNCED DEAD

10/30/65 8:46 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence, before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6411 Kenwood Ave. #6

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
married

8. DATE OF BIRTH

6/24/23

9. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Electric Assembly

10B. KIND OF BUSINESS OR INDUSTRY

Rowan Controller Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Philip Foote

14. MOTHER'S MAIDEN NAME

Myrtle Clemens

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Jane Foote, above, wife

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia due to compression of chest  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

yard

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

6411 Kenwood Ave.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10 30 65 8:30 p.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

auto fell on chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/31/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/4/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 3 1965

24B. NAME OF REGISTRAR

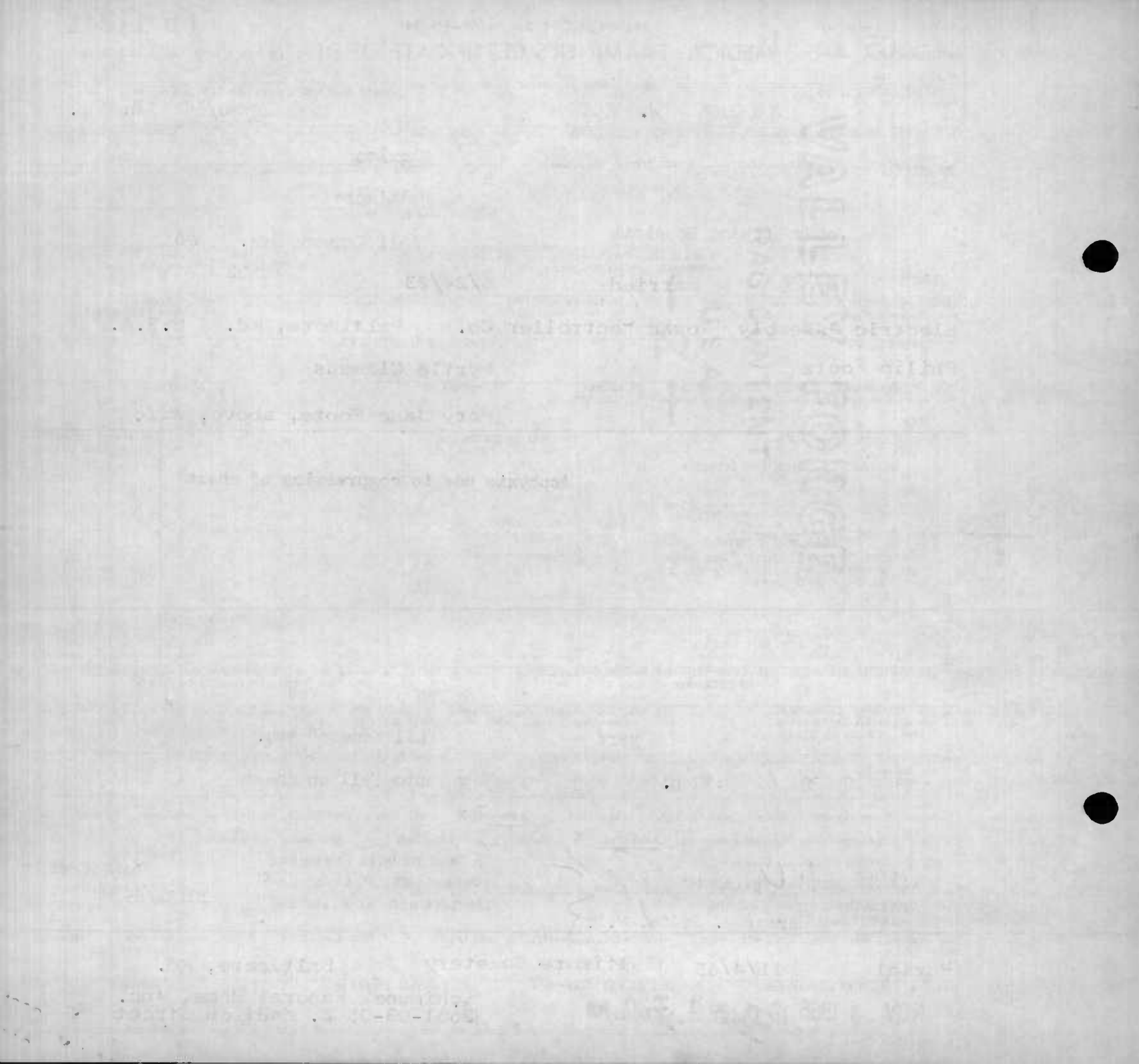
Robert E. Farber

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
2601-03-05 E. Madison Street #5

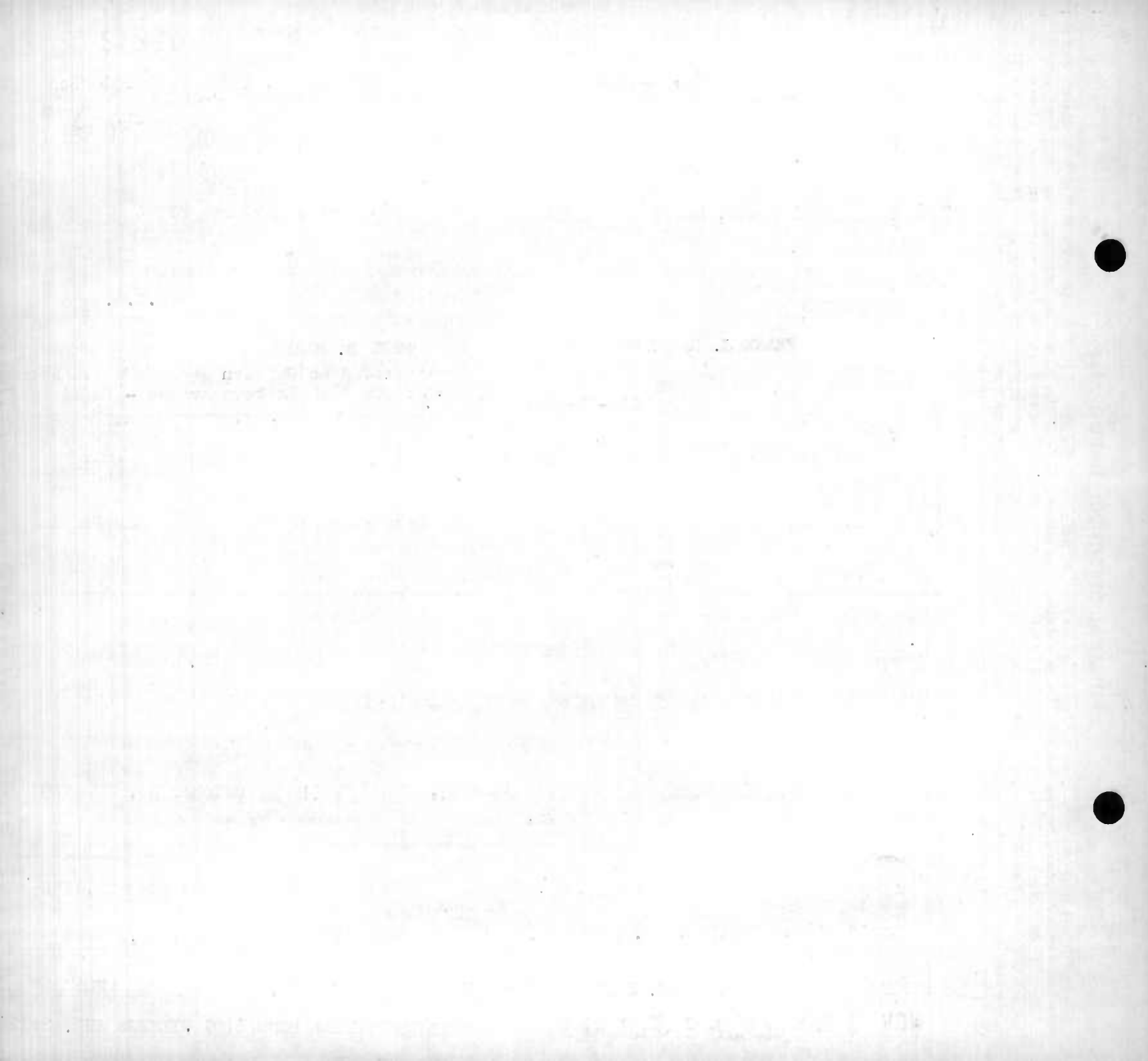
ADDRESS





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

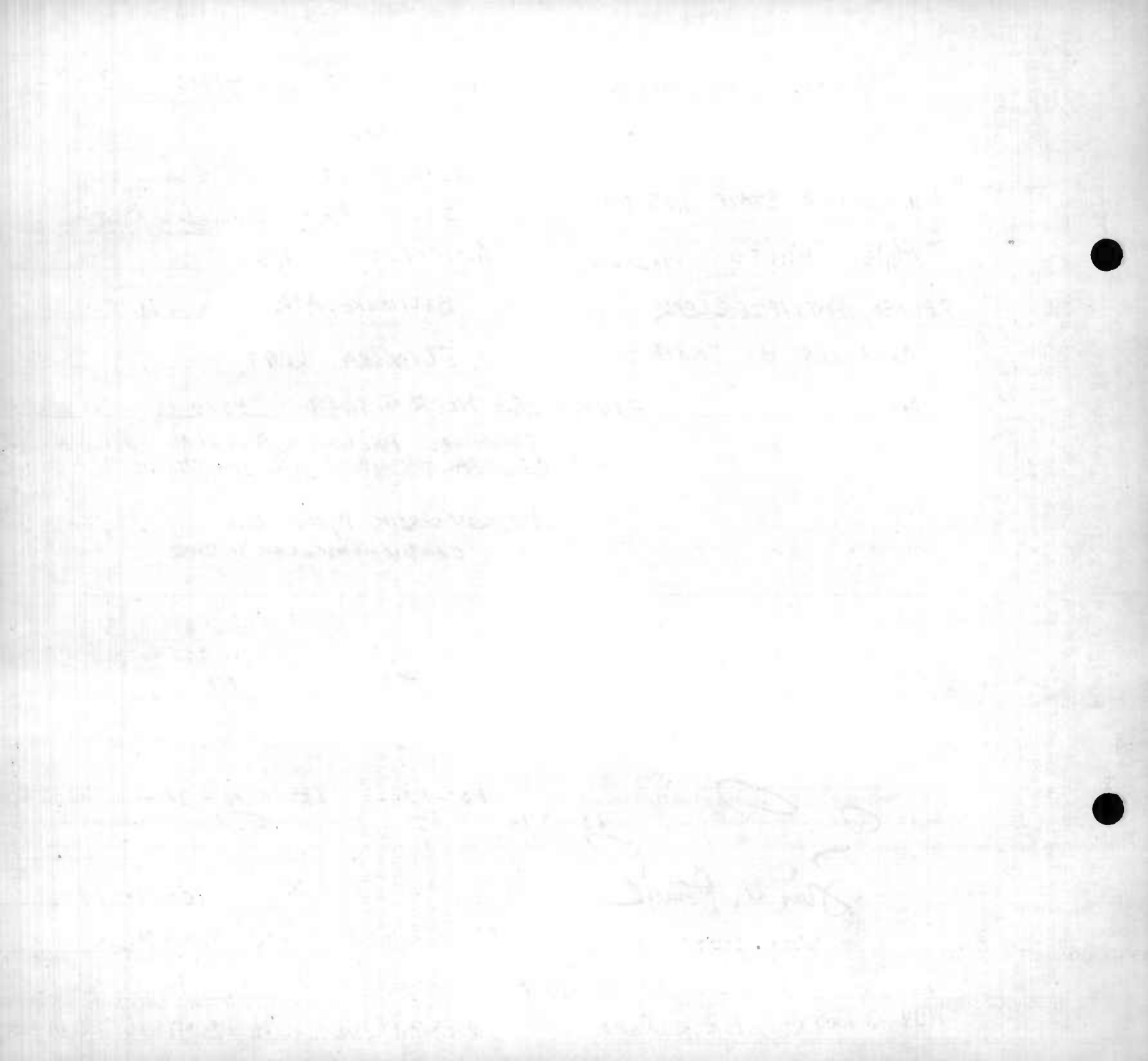
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11242	
BIRTH NO. 65 11242		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		HALLIGAN, Albert		2. DATE AND HOUR OF DEATH October 29, 1965 12:00 Noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Baltimore		D. STREET ADDRESS (If rural, give location)	
BCH 4940 Eastern Avenue 21224		B. DATE OF BIRTH		9. AGE (In years last birthday)	
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
UNEMPLOYED				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
FRANK J. HALLIGAN		MARY B. BLAKE		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		217-03-4039		Mrs. Anna Griffen 3605 Melavish Avenue RECORDS: BCH 4940 Eastern Avenue - 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Generalized cerebral degeneration DUE TO		years	
ANTECEDENT CAUSES		(B) Generalized arteriosclerosis DUE TO		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19, 1964 to October 29, 1965, that (I) (we) lost saw the deceased alive on October 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Pierce Curtiss, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED October 29, 1965	
23C. PHYSICIAN'S NAME (Type) David Pierce Curtiss, Jr.		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/1/65		24C. NAME of CEMETERY or CREMATORY ST. PETER'S CEMETERY	
BURIAL				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

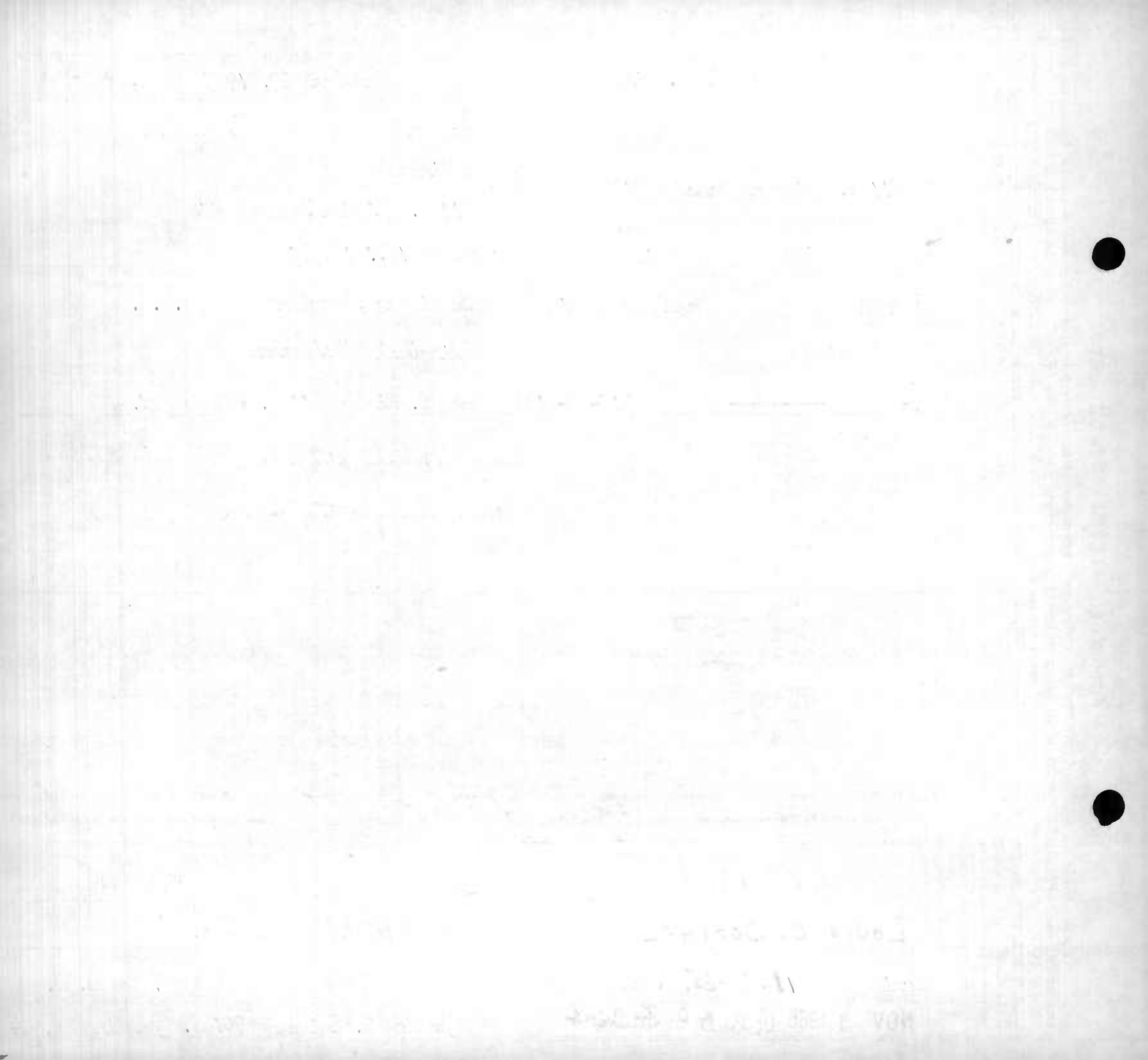
BIRTH NO. 65 11243		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11243	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SNAPP MR. CHARLES B. Jr.		10-31-1965		I: 45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
MONTEBELLO STATE HOSPITAL		MARYLAND		BALTO	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE		53-01	
		D. STREET ADDRESS (If rural, give location)			
		5510 HEATHERWOOD ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Male	White	MARRIED	4-10-1890	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
RETIRED POST OFFICE CLERK				U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
CHARLES B. SNAPP Sr.		ELIMOKA VOGT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-38-1083		MRS. R. B. SNAPP 5510 HEATHERWOOD Rd	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		ABOUT A WEEK	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		8 MONTHS	
		(C) DUE TO		? YEARS	
		TERMINAL PNEUMONIA, LOBAR CEREBRAL THROMBOSIS (R) HEMIPARESIS			
		ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10-13-1965 to 10-31-1965, that (I) (we) last saw the deceased alive on 10-31-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Zin U. Park				10-31-1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Zin U. Park		MONTEBELLO STATE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/3/65		London Park Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 3 1965		Robert E. Fairbank		Hubbard Funeral Home 4107 Wilkens Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11244	
BIRTH NO. 65 11244		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Joseph C. Kirby		2. DATE AND HOUR OF DEATH October 29, 1965 4:10 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY Baltimore			
811 S. Clinton Street 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 811 S. Clinton Street #24			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH October 17, 1918	9. AGE (In years last birthday) 47	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Merchant Marine	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Kirby		14. MOTHER'S MAIDEN NAME Elizabeth Wolferman		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-03-4146		17. INFORMANT Mary L. Kirby 811 S. Clinton St. #24			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) acute coronary thrombosis DUE TO (B) chr. coronary artery disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH about 1 hr. 3 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 4, 1962 to Oct 29, 1965 that (I) (we) last saw the deceased alive on Oct 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. C. Wohl		M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED 10/30/65	
23C. PHYSICIAN'S NAME (Type) LOUIS C. DOBIHAL		23D. ADDRESS 447 W. Kenwood Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-2-65		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION 7401 German Hill Rd. Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 3 1965			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Charles S. Zeiler 901 S. Conkling St. #24			





BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED

(Type or Print)

HARRY MULFORD

2. DATE AND HOUR PRONOUNCED DEAD

October 28, 1965

8:30

P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

27 N. Carey St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

27 N Carey St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Sept 4, 1899

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NOT KNOWN

14. MOTHER'S MAIDEN NAME

NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

29303-0352

17. INFORMANT

Mrs. MARIAN SULLIVAN

ADDRESS

1410 KINGSWAY RD  
BALTIMORE, MD

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Malnutrition and dehydration

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Oct. 29, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-1-65

23C. NAME OF CEMETERY or CREMATORY

Mt. Charet Cemetery

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

NOV 3 1965

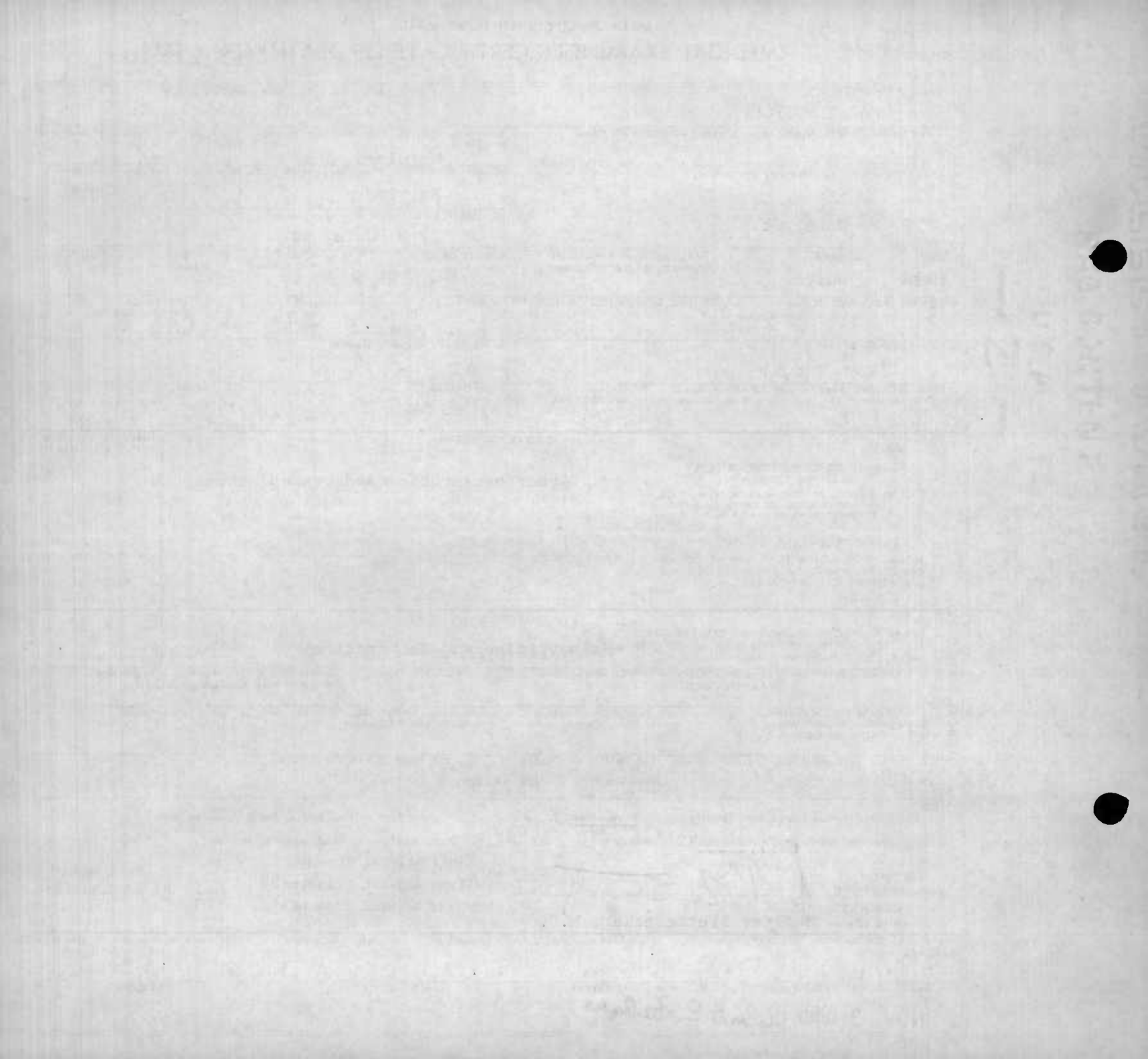
24B. NAME OF REGISTRAR

Robert E. Fink

24C. FUNERAL DIRECTOR

Wm. COOK BROOKS TOWSON 100 YORK RD  
TOWSON, MD 21204

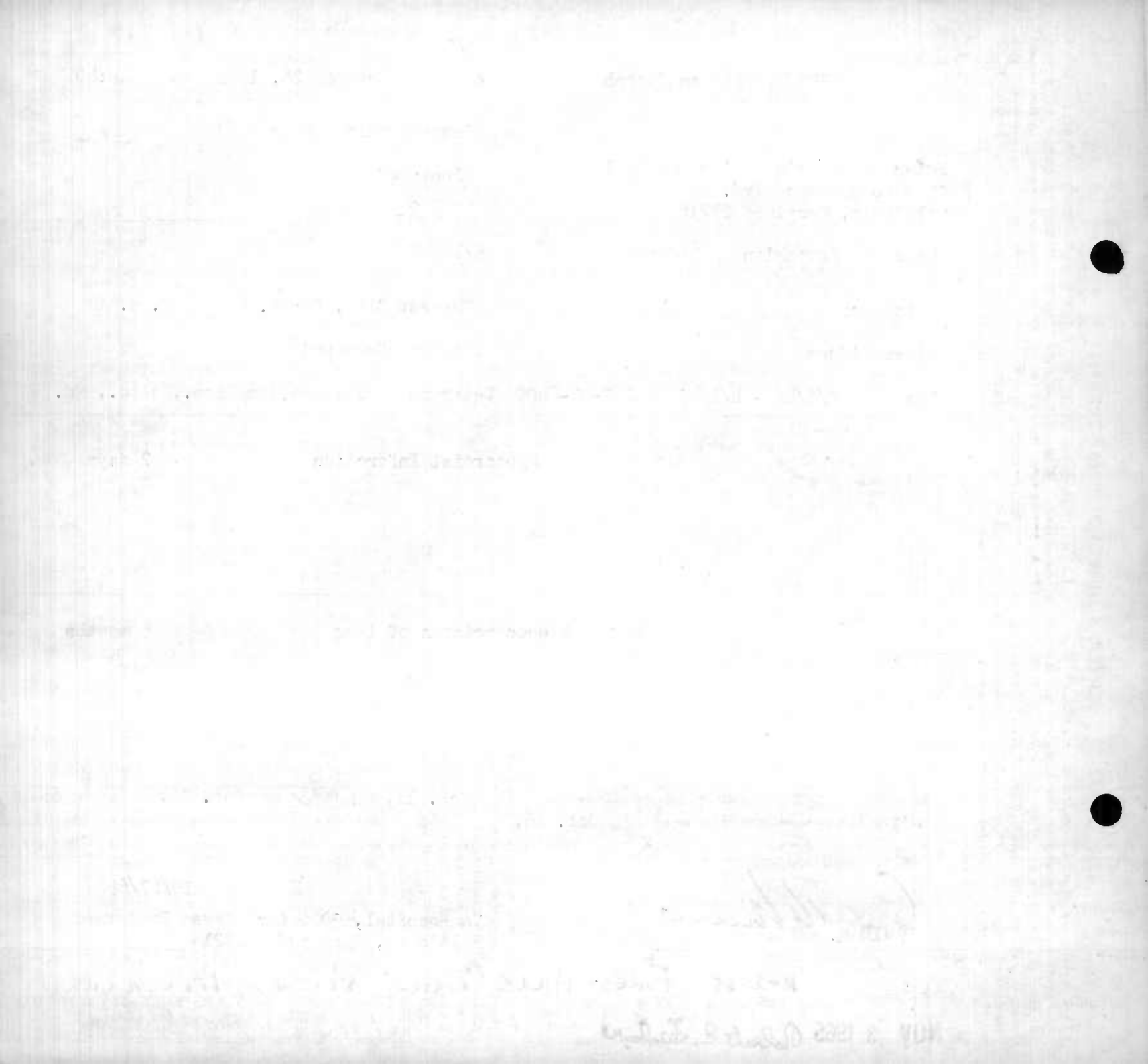
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11246				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11246	
1. NAME OF DECEASED (Type or Print) <b>WIDSON, William Joseph</b>				2. DATE AND HOUR OF DEATH <b>October 26, 1965</b>		<b>10:40</b>		<b>P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>Berks</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Fleetwood</b> D. STREET ADDRESS (If rural, give location) <b>RD # 2</b>					
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>5/14/97</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Forrest City, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>			
13. FATHER'S NAME <b>Peter Widson</b>				14. MOTHER'S MAIDEN NAME <b>Estelle (Unknown)</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 10/6/42 - 4/1/43</b>		16. SOCIAL SECURITY NO. <b>202-07-8409</b>		17. INFORMANT ADDRESS <b>Veterans Administration Hosp., Balto., Md.</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Adenocarcinoma of lung		6 months			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from <b>Oct. 11, 1965</b> to <b>Oct. 26, 1965</b> , that (X) (we) lost saw the deceased alive on <b>Oct. 26, 1965</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>DAVID N. MARINE</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/27/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>DAVID N. MARINE</b>				23D. ADDRESS <b>VA Hospital, 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-30-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>FOREST HILLS CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>READING, PENNSYLVANIA</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>WM. COOK BROOKS TOWSON 1050 YORK RD TOWSON, MD 21204</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-21491		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65-11247	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RONALD SHEEHY		2. DATE AND HOUR OF DEATH OCTOBER 29, 1965   9:20P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) TIMONIUM D. STREET ADDRESS (If rural, give location) 2520 POT SPRING ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) XXXXXX	B. DATE OF BIRTH 10-29-65	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	12. CITIZEN OF WHAT COUNTRY? 11 21
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME VIRGINIA SHEEHY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND CATON AVENUE ADDRESS ST. AGNES HOSPITAL RECORDS WILKENS	
18. 773.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Respiratory Distress Syndrome (B) DUE TO Prematurity 32 weeks old (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 29 1965 to OCTOBER 29 1965, that (X) (we) last saw the deceased alive on OCTOBER 29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Hernandez M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore Md		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1965		25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR Theresa Funeral Home 1216 S. Charles	
25D. ADDRESS		25E. ADDRESS			

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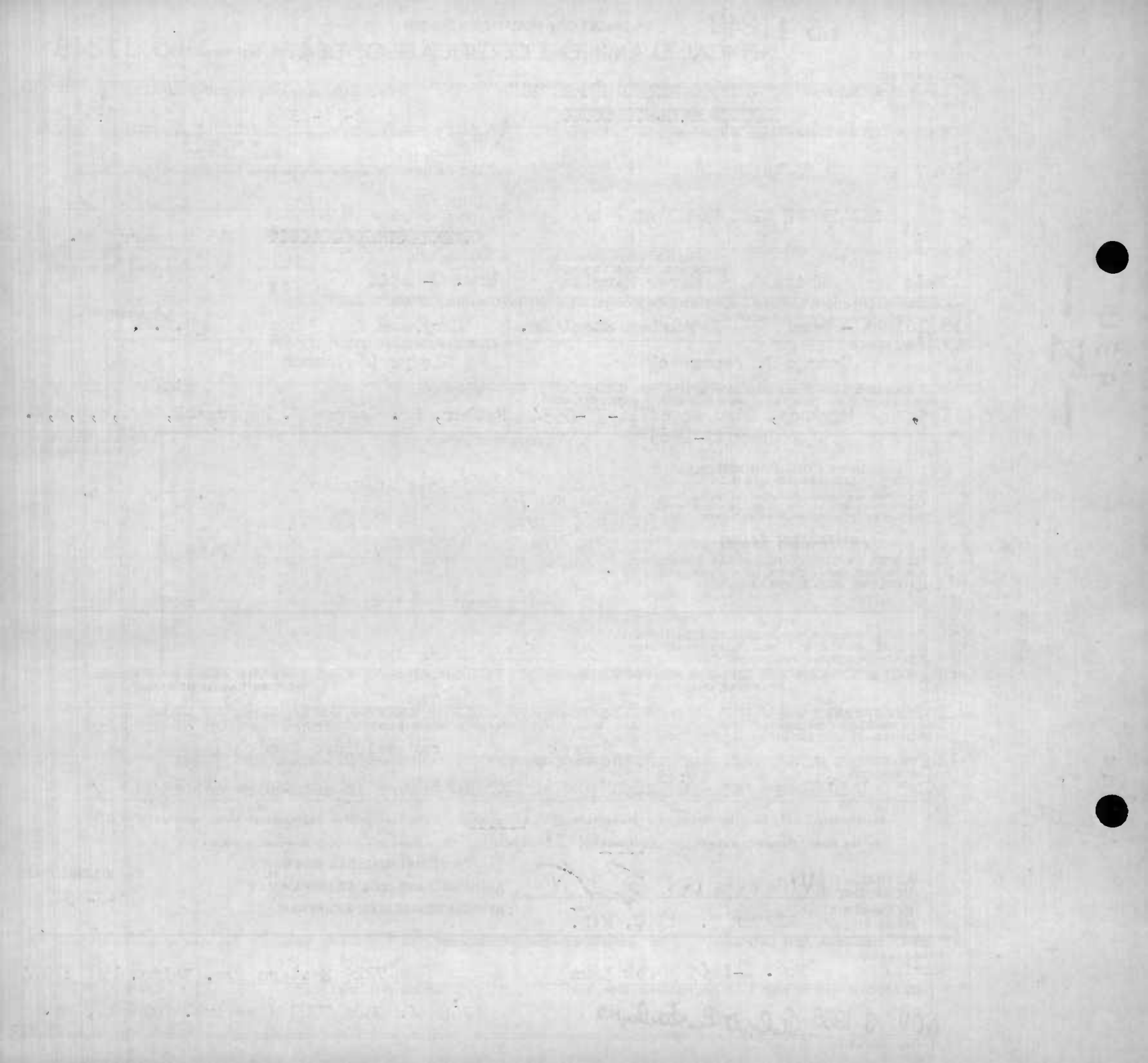
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 44-75-88				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11248	
M.E. CASE NO.				BIRTH NO. 65 11248			
1. NAME OF DECEASED (Type or Print) Almyra S. Hendrix				2. DATE AND HOUR OF DEATH October 31, 1965   8:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224				USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3925 Canterbury Road, #21218			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 2-1-1885	9. AGE (In years last birthday) 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Walter			14. MOTHER'S MAIDEN NAME Eugenia V. Snyder				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. 217-09-39				
17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., #21224			ADDRESS				
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Aspiration DUE TO (B) Pneumonia DUE TO (C) Recurrent Vomiting		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Cerebral Vascular Accident							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from September 20, 19 65 to October 31, 19 65, that (I) (we) last saw the deceased alive on October 31, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stephen Gregg				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED October 31, 1965	
23C. PHYSICIAN'S NAME (Type) Stephen Gregg				23D. ADDRESS M.D. 4940 Eastern Avenue, Balto., Md., #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/65		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202			



Letter from K. C. H.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 11250</u>	
BIRTH NO. <u>65 11250</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>KARCZEWSKI, JOHN</u>		2. DATE AND HOUR OF DEATH <u>10-31-65 4-24 Pm.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>26-36</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>1204 Delbert Ave. — 21224</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10-23-1900</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Released from Ind Balto Hotel &amp; Balto. City Police</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>G. GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Anthony Karczewski</u>		14. MOTHER'S MAIDEN NAME <u>ANNA GORSKI</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes, Coast Guard, Feb. 1920</u>		16. SOCIAL SECURITY NO. <u>213-28-7268</u>		17. INFORMANT <u>Life of patient on admission</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>570.5 to April 1922</u>		CAUSE OF DEATH (A) <u>ASPIRATION GASTRIC CONTENTS</u> DUE TO (B) <u>SMALL BOWEL OBSTRUCTION</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Two days</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u> or <u>NA</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NA</u>		20A. AUTOPSY? (Yes or No) <u>— NO —</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>OCT-30-1965</u> to <u>OCT-31-1965</u> ; that (I) (we) last saw the deceased alive on <u>OCT 31 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. S. Dureshi</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10-31-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. S. DURESHI</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL BALTIMORE 21201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Nov. 4-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus</u>	
24D. LOCATION (City, town, or county) (State) <u>Dundalk Ave. Balto. Md. 21224</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>JOHN J. DUDA 2829 Hudson St. Balto. Md. 212</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 11251		CERTIFICATE OF DEATH				Registered No. 65 11251			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SCOTT, BABY BOY				2. DATE AND HOUR OF DEATH 11-1-65 1:30 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
5. SEX MALE						6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 11-1-65		9. AGE (In years last birthday) 8		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 30	
13. FATHER'S NAME JOHN SCOTT						14. MOTHER'S MAIDEN NAME BEULAH BRITTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 763.5 I aspiration pneumonia						INTERVAL BETWEEN ONSET AND DEATH 8 1/2 hr			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) Prematurity			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5 AM Nov. 19 65 to 1:30 PM Nov. 19 65, that (I) (we) last saw the deceased alive on 1 Nov. 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Paul H. Viisscher M.D.						23B. DATE SIGNED 1 Nov 65			
23C. PHYSICIAN'S NAME (Type) PAUL H. VISSCHER						23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 11-2-65		24C. NAME of CEMETERY or CREMATORY JOHNS HOPKINS HOSPITAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, 5, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 3 1965						HOSPITAL DISPOSAL			

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# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 27431 65 11252				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11252	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Kolar, BABY BOY		11-1-65 6:50 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
33 THE JOHNS HOPKINS HOSPITAL				MARYLAND			
5. SEX MALE				6. RACE WHITE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED				8. DATE OF BIRTH 10-31-65		9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JEROME KOLAR				SHIRLEY PEYTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 773.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO		28 hrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 31 Oct 65 19 to 1 Nov 1965, that (1) (we) last saw the deceased alive on 1 Nov 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
PAUL H VISSCHER M.D.				JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
CREMATION		11-2-65		JOHNS HOPKINS HOSPITAL		BALTIMORE 5, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 3 1965		Robert E. Fisher, M.D.		HOSPITAL DISPOSAL			

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## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>65 11253</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 11253</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>(Katie) Katherine Gaskins</u>		2. DATE AND HOUR OF DEATH <u>11-1-1965</u> <u>5 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>19-04</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1701 Hollins Street</u> <u>21223</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3 -31-1877</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Bronhaver</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Koch</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Son, Clayton Gaskins, 716 Murdock Rd</u> <u>Records: BCH-4940 Eastern Avenue 21224</u>	
18. <u>422. LATE 904.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Generalized Atherosclerosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>with Chronic Brain Syndrome</u> <u>and Cardiac Insufficiency</u>		19. CAUSE OF DEATH <u>Generalized Atherosclerosis</u> <u>with Chronic Brain Syndrome</u> <u>and Cardiac Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>states Post (R) Hip Fracture</u>		20. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1701 Hollins St.</u>	
21D. TIME OF INJURY (APPROX.) <u>10 9 65-2 PM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>fall</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>10-27-</u> <u>1965</u> to <u>11-1-</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>11-1-</u> <u>19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David Pierce Curtiss Jr.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-1-1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>David Pierce Curtiss Jr.</u>		23D. ADDRESS M.D. <u>4940 Eastern Avenue, Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>Nov. 3/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park</u>	
24D. LOCATION <u>Balto. 29, Md</u>		24E. NAME OF REGISTRAR <u>Robert E. Fink</u>		24F. FUNERAL DIRECTOR <u>Witzke F.D. 4101 Edmondson Ave</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fink</u>		25C. FUNERAL DIRECTOR <u>Witzke F.D. 4101 Edmondson Ave</u>	

(12/1/71)

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

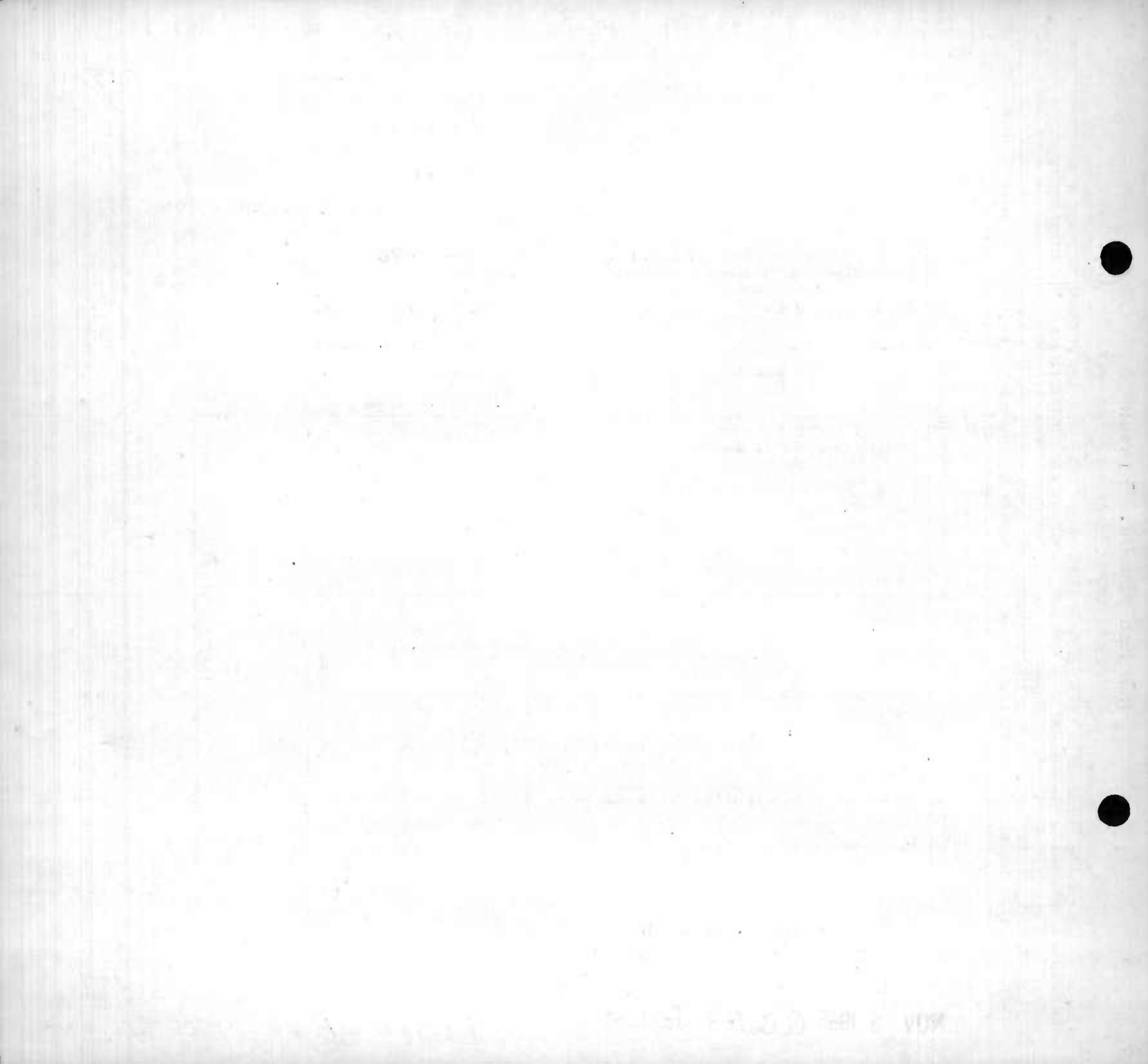
BIRTH NO. 65 11254		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11254	
M.E. CASE NO.		CERTIFICATE OF DEATH		11/2/65 1:45 A.M.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SARAH GREEN					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL		MARYLAND BALTIMORE			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
FEMALE		NEGRO		MARRIED	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
8-25-09		56		Houswife	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
BALTO, MD.		U.S.A.		UNK	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
UNK.		No		219-224274	
17. INFORMANT		ADDRESS			
RAYMOND GREEN		109 Center			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10/11/65 to 11/2/65, that (1) (we) last saw the deceased alive on 11/2/65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Daniel G. Robinhold, M.D.		11/2/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DANIEL G. ROBINHOLD, M.D.		J.H.H.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11-5-65		CARVER MEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 3 1965		Robert E. Fisher, M.D.		MORTON A. DYETT	
				ADDRESS 1701 Laurens	



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BIRTH NO. 65 11255		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11255	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>VIRGIE Jones</i>		
2. DATE AND HOUR OF DEATH 11-1-65 2:55PM M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 2235 PENROSE AVENUE		ZONE 23			
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-23-86	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Talbot Co., Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME JAMES MOORE			
14. MOTHER'S MAIDEN NAME ELLEN ROSS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. John Jones</i> ADDRESS <i>103 S. Center ST. Md.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>INTESTINAL Obstruction</i> DUE TO <i>2° Diphyllobothrium + Renal Failure</i> (B) <i>Failure</i> DUE TO (C) <i>Associated CHF</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Approx 1 wk</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Reaction</i> <i>CARCINOMA of thyroid</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-31-65</i> 19 <i>65</i> to <i>11-1-65</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>11-1</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John D. Harrah</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-1-65</i>	
23C. PHYSICIAN'S NAME (Type) JOHN D. HARRAH		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-4-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 3 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>MORTON &amp; DYETT</i> ADDRESS <i>1701 Laurens</i>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 11256		65 11256		65 11256	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Mary Margaret Covell			11-2-65 12:10P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
40 ST AGNES HOSPITAL			MARYLAND 16-08		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			603 N. WOODINGTON RD. 21229		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	SINGLE	3-1-12	53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PAYROLL Clerk		Butler Brothers		MARYLAND	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
LUTHER COVELL			U.S.		
14. MOTHER'S MAIDEN NAME			17. INFORMANT		
NELLIE M. Spencer			CATON AVES. 21229		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO			215-09-6727		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-11-19 65 to 11-2-19 65, that (I) (we) last saw the deceased alive on 11-2-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Vincenzo G. Rubin M.D.				11-2-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
VINCENTE RUBIN				ST AGNES HOSPITAL, BALTIMORE 29, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/5/1965		Loudon Park Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 3 1965		D. E. F. F. F.		Wm. J. Fickner & Sons	
				Baltimore, Md. 100 North & Pa. Ave.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11257		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11257	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Frank H. Stewart		Oct. 31, 1965		11.40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
528 W. Biddle St.		Md.		17-01	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Balto.			
		D. STREET ADDRESS (If rural, give location)			
		528 W. Biddle St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	Colored	Widow	Nov. 28, 1878	86	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Porter Retired		Club		Keddyville Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
David Stewart		Annie ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		212-10-7524		Gwendolyn Reeder 528 W. Biddle St.	
18. 420.01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) ASHOC Cong. Failure		8/63 (2+4)	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/5 1963 to 10/31 1965 that (I) (we) last saw the deceased alive on 8/16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
J. Preston Grant				11/2/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. Preston Grant,		601 N. Carroll Ln.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Nov. 3, 1965		Mt. Auburn Cem.	
				Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 3 1965		Robert E. Farber		Williams Funeral Home 319 N. Schowdt St.	



45-02-17

JJ

H-400

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11258		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11258	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LOUISE HILL			2. DATE AND HOUR OF DEATH 10-31-65 6:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1702 N. CHAPEL ST. #21213		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-7-25	9. AGE (In years last birthday) 40	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME WILLIE DRAUGHN		
14. MOTHER'S MAIDEN NAME MAGGIE PITT			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 242-42-1414			17. INFORMANT ADDRESS RECORDS: BCH-4940 EASTERN AVENUE - #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLUS DUE TO UREMIA DUE TO CHRONIC RENAL DISEASE			INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 3-4 MONTHS 8-10 YEARS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-22-19 65 to 10-31-19 65, that (I) (we) last saw the deceased alive on 10-31-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Gregg			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/31/65
23C. PHYSICIAN'S NAME (Type) DR. STEPHEN GREGG			23D. ADDRESS M.D. 4940 EASTERN AVENUE - #21224		
24A. BURIAL CREMATION, REMOVAL (Specify) 10-4-65 BURIED		24B. DATE 11-4-65		24C. NAME OF CEMETERY or CREMATORY MT-CALVARY	
24D. LOCATION (City, town, or county) (State) a.a. COUNTY Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 3 1965			
25B. NAME OF REGISTRAR Robert E. Staker		25C. FUNERAL DIRECTOR ADDRESS JOSEPH KNIGHT 1639 N. MOUNT ST.			





Released on Approval of *Approved by Med Examiner Dr Spitts* to The Johns Hopkins Hospital

by **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11259		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11259	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Herbert Keys</i>		2. DATE AND HOUR OF DEATH <i>11/2/65 13:16 P M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-04</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1818 Walbrook Avn. WALBROOK</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>March 15, 1901</i>	9. AGE (In years lost birthday) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Landscaping</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Westmoreland Co., Virginia</i>	
13. FATHER'S NAME <i>Buckhana Keys</i>		14. MOTHER'S MAIDEN NAME <i>XX Lucy Banks</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Margaret Keys - 1818 Walbrook Ave.</i>	
18. <i>022X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerosis</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Arteriosclerosis</i> (B) <i>Due to</i> (C) <i>Due to</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>	
19A. DATE OF OPERATION <i>11/2/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Arteriosclerosis</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work - At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>Oct 27,</i> 19 <i>65</i> to <i>11/2/</i> 19 <i>65</i> , that (we) lost saw the deceased alive on <i>11/2/65</i> 19 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>H.R. Gertner Jr.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/2/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Harold R. Gertner Jr.</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-5-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National</i>	
24D. LOCATION <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 3 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law</i>	
				ADDRESS <i>802 Madison Ave.</i>	

See Letter in File - Bur. of Reclamation  
American Bridge

1  
B650

65 11260

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11260

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Anna Anne Brown

2. DATE AND HOUR PRONOUNCED DEAD

10/31/65 8:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

925 Bevan St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

925 Bevan St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

1/10/13

9. AGE (in years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Palmer

14. MOTHER'S MAIDEN NAME

Annie Boone

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Annie Boone 925 Bevan St.

18.

416X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Rheumatic heart disease  
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN VERIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner H. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/31/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/4/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 3 1965

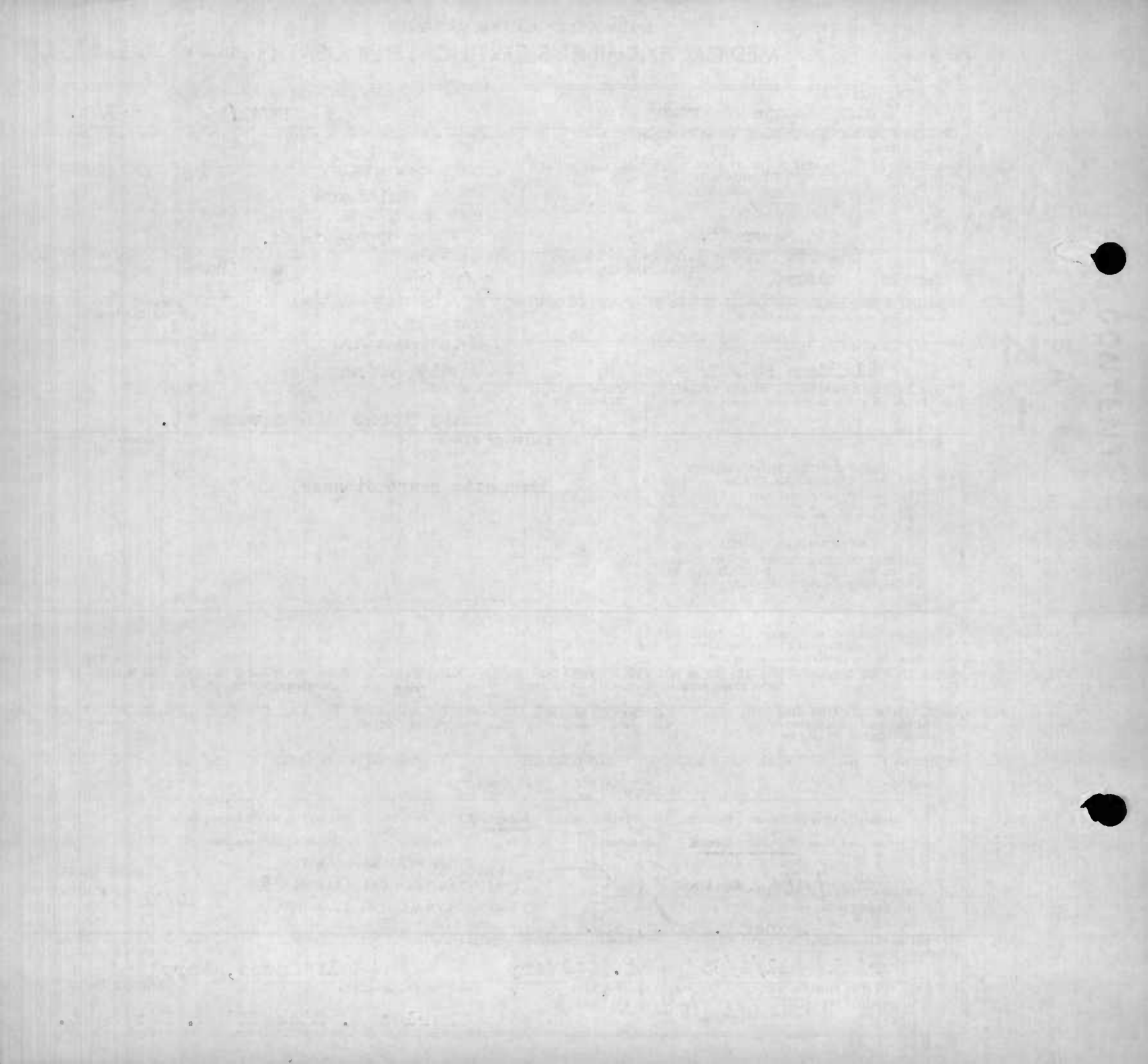
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.



65 11261

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11261

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WAVERLY HARRIS

2. DATE AND HOUR PRONOUNCED DEAD

10-31-65

10:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

145 S. Hilton Street 21229

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4/30/09

9. AGE (in years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Andrew Harris

14. MOTHER'S MAIDEN NAME

Adlea Branch

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Rebecca Harris 145 S. Hilton St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Pulmonary infarction

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-1-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/6/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 3 1965

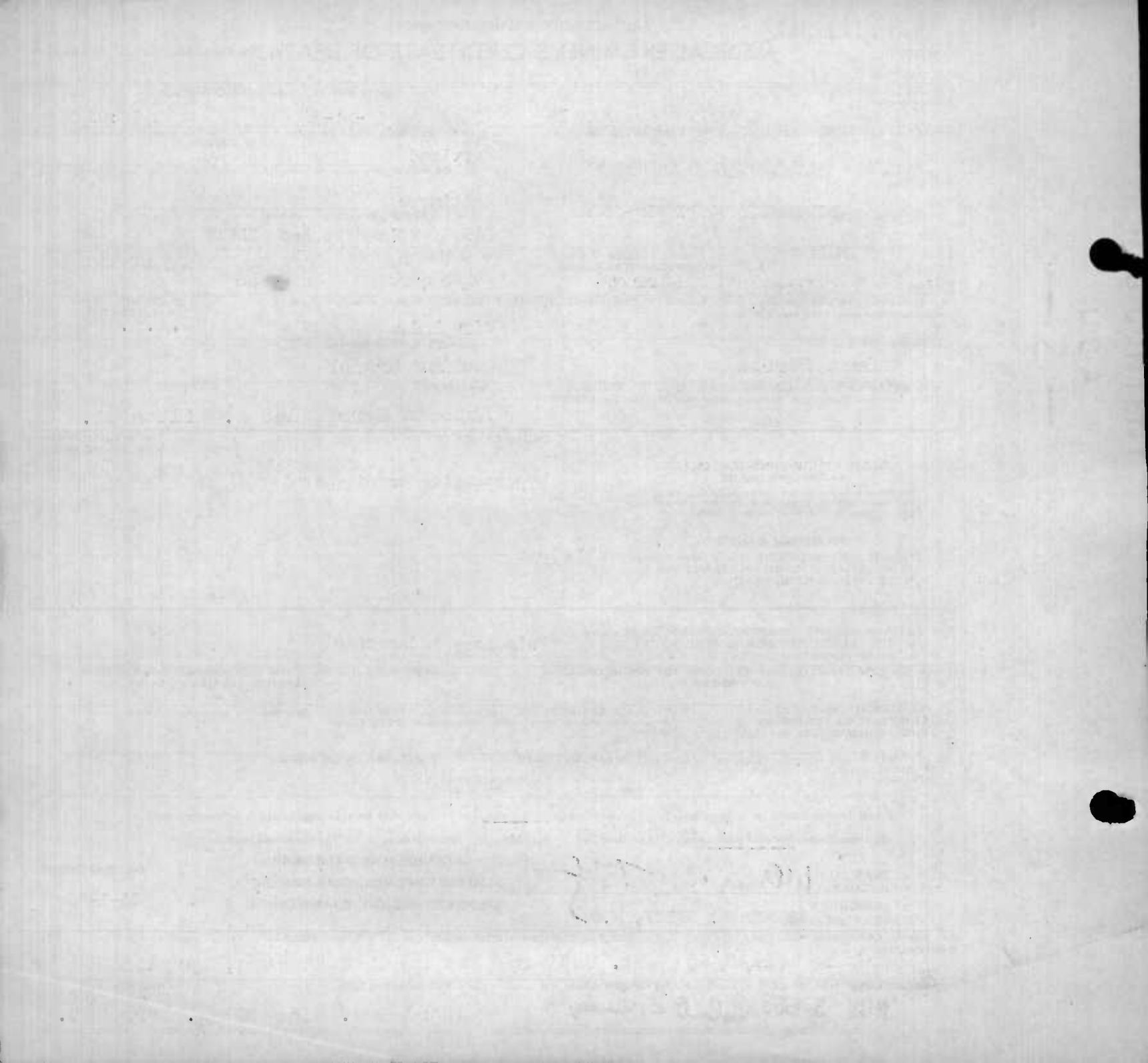
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.





65 11262

BALTIMORE CITY HEALTH DEPARTMENT

65 11262

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

VERNON C. MERRICK

2. DATE AND HOUR PRONOUNCED DEAD

11/2/65 12:25 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5 N. Gilmer St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

7/7/28

9. AGE (In years  
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Charles Merrick

14. MOTHER'S MAIDEN NAME

Hattie DeShields

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred B. Woods 1007 W. Fayette St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive pulmonary embolism  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN DETERMINING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/2/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/5/65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 3 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.



WALDE FOLIO

CONTINUED

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11263		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11263	
M.E. CASE NO. 65 11263		Perrera		2. DATE AND HOUR OF DEATH 10/31/65 9 A.M.	
1. NAME OF DECEASED (Type or Print) Orlando Perrera		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married.	
8. DATE OF BIRTH AUG 19 1920		9. AGE (In years last birthday) 45		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME IMPROVEMENTS		10B. KIND OF BUSINESS OR INDUSTRY RES.		11. BIRTHPLACE (State or foreign country) CONN.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SALVATORE PERRERA		14. MOTHER'S MAIDEN NAME CONCETTA M. DE MARTINA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RD. MRS. MARGO PERRERA 6804 BROMPTON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Acute pulmonary edema (B) DUE TO Acute myocardial infarction (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 10/31 1965 to 10/31 1965, that (I) (we) last saw the deceased alive on 10/31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE E. L. Robbins M.D.		23B. DATE SIGNED 10/31/65		23C. PHYSICIAN'S NAME (Type) M.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE NOV. 3/65		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT NOV 3 1965		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR ADDRESS 322 S. High St. Frank J. Keller	

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Handwritten text in the middle section of the page, appearing to be a list or series of notes.

Handwritten text in the lower middle section of the page, continuing the notes or list.

Handwritten text at the bottom of the page, possibly a conclusion or signature.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11264</b>	
BIRTH NO. <b>65 11264</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Patricia LEAN Rix</b>	
2. DATE AND HOUR OF DEATH <b>Nov. 2, 1965 11:42 P.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION <b>md. GEN. Hosp</b>		(If not in hospital or institution, give street address or location)	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>BALTO</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO #22 3370</b>	
D. STREET ADDRESS (If rural, give location) <b>213 Colgate Ave</b>		5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NB</b>	
8. DATE OF BIRTH <b>Nov. 2, 1965</b> 9. AGE (In years last birthday) <b>2</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. <b>2</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Arnold Rix</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA Ione Burke</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mother</b>		ADDRESS <b>Same</b>	
18. <b>75-0X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANENCEPHALY</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 MIN</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 2 1965</b> to <b>Nov 2 1965</b> , that (I) (we) last saw the deceased alive on <b>Nov 2 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Donald J. [Signature]</b> M.D.		23B. DATE SIGNED <b>11/2/65</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/3/65</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Carmel</b>		24D. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>S.W. [Signature]</b>		ADDRESS <b>3218 Hudson St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 2em;">65 11265</span>	
BIRTH NO. <span style="font-size: 2em;">65 11265</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">HAMIEL, Waverly</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10-31-65</span> <span style="float: right;">3:20 A. M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Provident Hospital 1514 Division Street</span>		A. STATE <span style="font-size: 1.2em;">Newark, New Jersey</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Newark</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">468 Washington Street</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10-6-02</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">63</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">None</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">North Carolina</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">William Hamiel</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Anna Smith</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">10-16-42-4-29-43 136 09 0434</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Leah Pierce</span> ADDRESS <span style="font-size: 1.2em;">2807 Baker Street Baltimore, Maryland</span>	
18. <span style="font-size: 1.2em;">15311</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Pulmonary Edema</span>		CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Pulmonary Edema</span> (B) <span style="font-size: 1.2em;">Localized Peritonitis</span> (C) <span style="font-size: 1.2em;">Ruptured Carcinoma of the Transverse Colon</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">one day</span>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2 None</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">-</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">Yes</span>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">-</span>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">-</span>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <span style="font-size: 1.2em;">-</span>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">-</span>		22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">October 30 (10:45) 1965</span> to <span style="font-size: 1.2em;">Oct 31, 1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">October 31, 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">Archie Robinson</span>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">11-1/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ARCHIE ROBINSON, JR.</span>		23D. ADDRESS <span style="font-size: 1.2em;">803 N. Fremont Avenue Baltimore, Maryland 21217</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">Nov 5, 1965</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">National Cem</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Newark N. J.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">NOV 3 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Joseph L. Russ</span>		ADDRESS <span style="font-size: 1.2em;">2222 W. North Ave Baltimore Md</span>			

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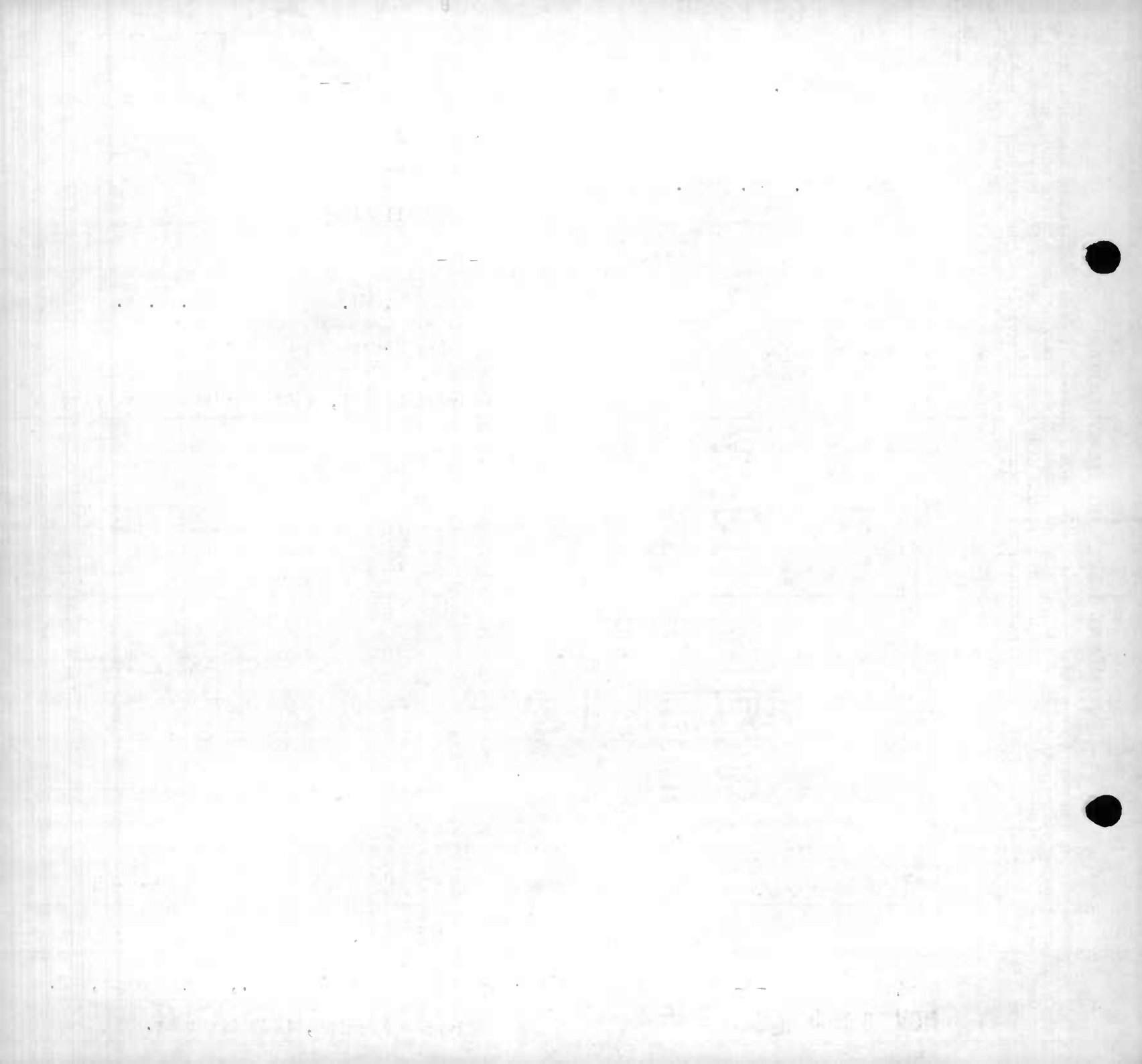
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 11266</span>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <span style="float: right;">65 11266</span></p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>MARIE M. BISESI</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>11-2-65</b></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Balto. Gen. Hosp. DOA</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>1127 Hall Alley</b></p>		
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b></p>	<p>8. DATE OF BIRTH <b>7-27-1903</b></p>	<p>9. AGE (In years last birthday) <b>62</b></p>	<p>If Under 1 Yr. Months: Days: Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>			<p>11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b></p>
<p>13. FATHER'S NAME <b>John Boidy</b></p>			<p>14. MOTHER'S MAIDEN NAME <b>Daisy Jackson</b></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>None</b></p>	<p>17. INFORMANT ADDRESS <b>Charles Bisesi, 5352 Patrick Henry Drive 25</b></p>		
<p>18. CAUSE OF DEATH</p> <div style="display: flex;"> <div style="flex: 1;"> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) DUE TO <b>Coronary occlusion</b></p> <p>(B) DUE TO <b>Arterio sclerotic heart disease</b></p> <p>(C) <b>Diabetes mellitus</b></p> </div> <div style="flex: 1;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>immediate</b></p> <p><b>1 to 2 years</b></p> <p><b>?</b></p> </div> </div>					
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION <b>0</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <b>No</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>February 23, 1965</b> to <b>November 2, 1965</b>, that (I) (we) last saw the deceased alive on <b>October 27, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <i>Harry Deibel</i></p>				<p>23B. DATE SIGNED <b>11-3-65</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>Harry Deibel</b></p>				<p>23D. ADDRESS <b>1226 S. Hanover Street Balto 20</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>11-6-65</b></p>		<p>24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b></p>	
<p>24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy., Glen Burnie, Md.</b></p>					
<p>25A. DATE REC'D BY HEALTH DEPT. <b>NOV 3 1965</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Taylor</b></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <b>Flynn &amp; Fleming, 1422 Light St.</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11267		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11267	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Alice Cook		
2. DATE AND HOUR OF DEATH Oct. 31, 1965 6:15 P.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LAKE Drive Nursing Home 2401 Estaw PLACE Baltimore 17, Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland 76-03		
5. SEX F			6. RACE W		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH 3/20/1888		
9. AGE (In years last birthday) 77			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
11. BIRTHPLACE (State or foreign country) Baltimore			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Philip Williams			14. MOTHER'S MAIDEN NAME Elizabeth Simpson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None			16. SOCIAL SECURITY NO. None		
17. INFORMANT Ethel King, Above, dght.			ADDRESS		
18. 420.0 I CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Acute congestive failure one hour		
ANTECEDENT CAUSES			(B) Arterioscl. Heart dis. chronic		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Generalized Art. Sclerosis chronic		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 26 19 64 to Oct 31 19 65, that (I) (we) last saw the deceased alive on Oct 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis V. Blum, M.D.				23B. DATE SIGNED 11/1/65	
23C. PHYSICIAN'S NAME (Type) Louis V. Blum, M.D.				23D. ADDRESS 3502 W. Rogers Ave, Baltimore 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/65		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) Baltimore, Md.		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR'S ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane #13	

First name 12/11/14  
Last name 12/11/14

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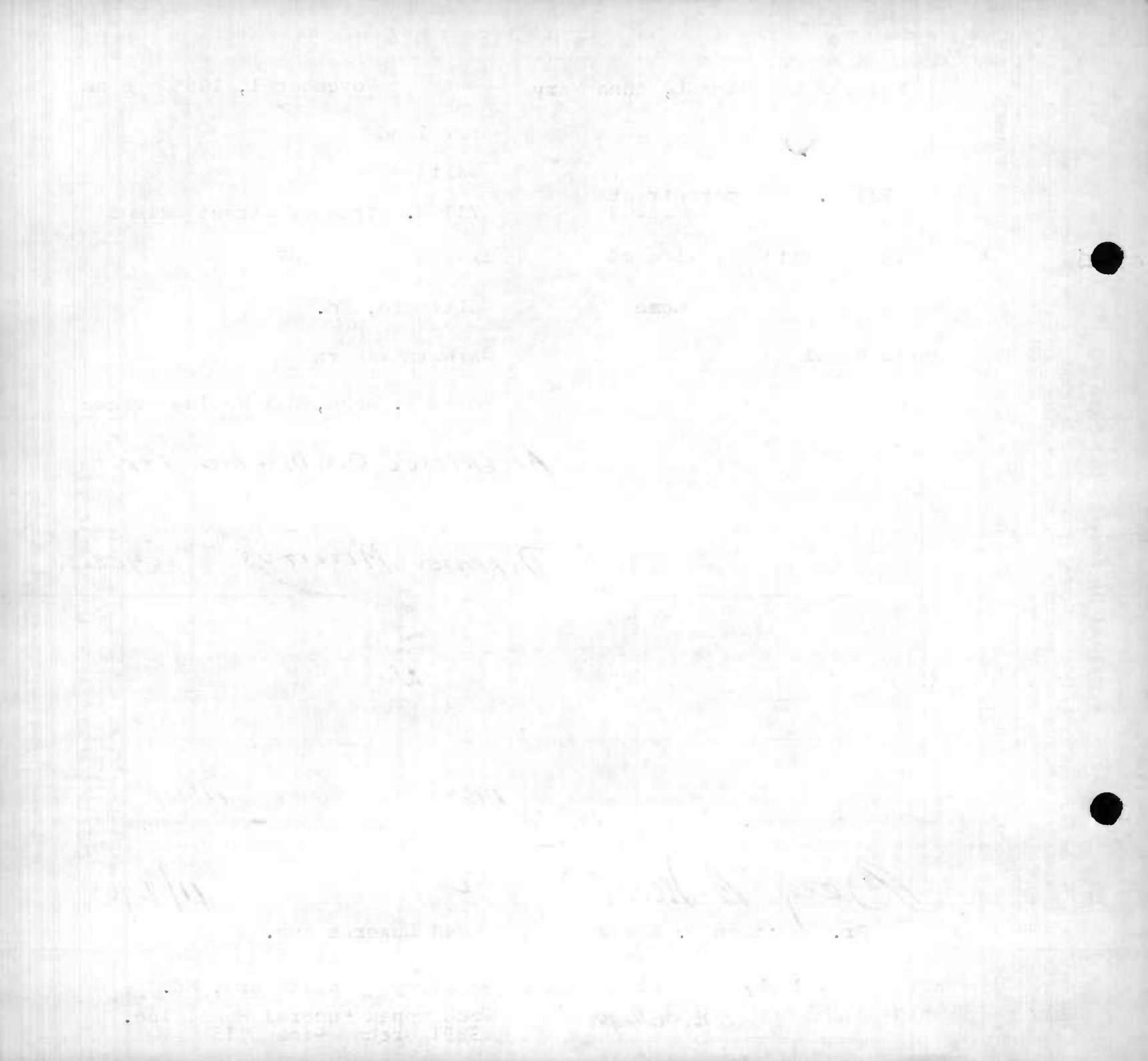
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# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11268		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11268	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MATEJKA OR MICHAEL, Anna Mary</b>			2. DATE AND HOUR OF DEATH <b>November 1, 1965 8 am M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>711 N. Streeper Street 21205</b>			A. STATE <b>Maryland</b> B. COUNTY <b>HOL</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>711 N. Streeper Street 21205</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>1/9/98</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Ignatz Biebl</b>			14. MOTHER'S MAIDEN NAME <b>Barbara Vivara</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Doris M. Sohn, 4021 Ardley Avenue</b>
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>ARTERIOSCL. C.V.D. DISEASE</b> DUE TO (B) DUE TO (C) <b>DIABETES MELLITUS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14Y.</b> <b>10 YEARS</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>11/1/65</b> that (I) (we) last saw the deceased alive on <b>10/27/65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Benjamin B. Moses</b> M.D.				23B. DATE SIGNED <b>11/2/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin B. Moses</b> M.D.				23D. ADDRESS <b>448 Luzerne Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/4/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane #13</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11269		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11269	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Johnson, Helen Maude			2. DATE AND HOUR OF DEATH 10-31-65 5:10 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 15-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1352 Fremont Ave		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12-5-98	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Louis Brown			14. MOTHER'S MAIDEN NAME Brace Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-14-527		17. INFORMANT Chart	
18. 5-60.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Cardiac Arrest DUE TO (B) Aspiration Gastric contents DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10
19A. DATE OF OPERATION 3 10-26-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ventral Hernia		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-17 19 65 to 10-31 19 65, that (I) (we) last saw the deceased alive on 10-31 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nelson J. Keeler, Jr. M.D.				23B. DATE SIGNED 10-31-65	
23C. PHYSICIAN'S NAME (Type) Nelson Keeler, Jr.		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-7-65		24C. NAME OF CEMETERY or CREMATORY Church Cem.	
24D. LOCATION Clonester VA.		24E. DATE REC'D BY HEALTH DEPT. NOV 3 1965			
25A. NAME OF REGISTRAR Robert E. Farley		25B. FUNERAL DIRECTOR George A. Kib - 1348 N. Calhoun St.			



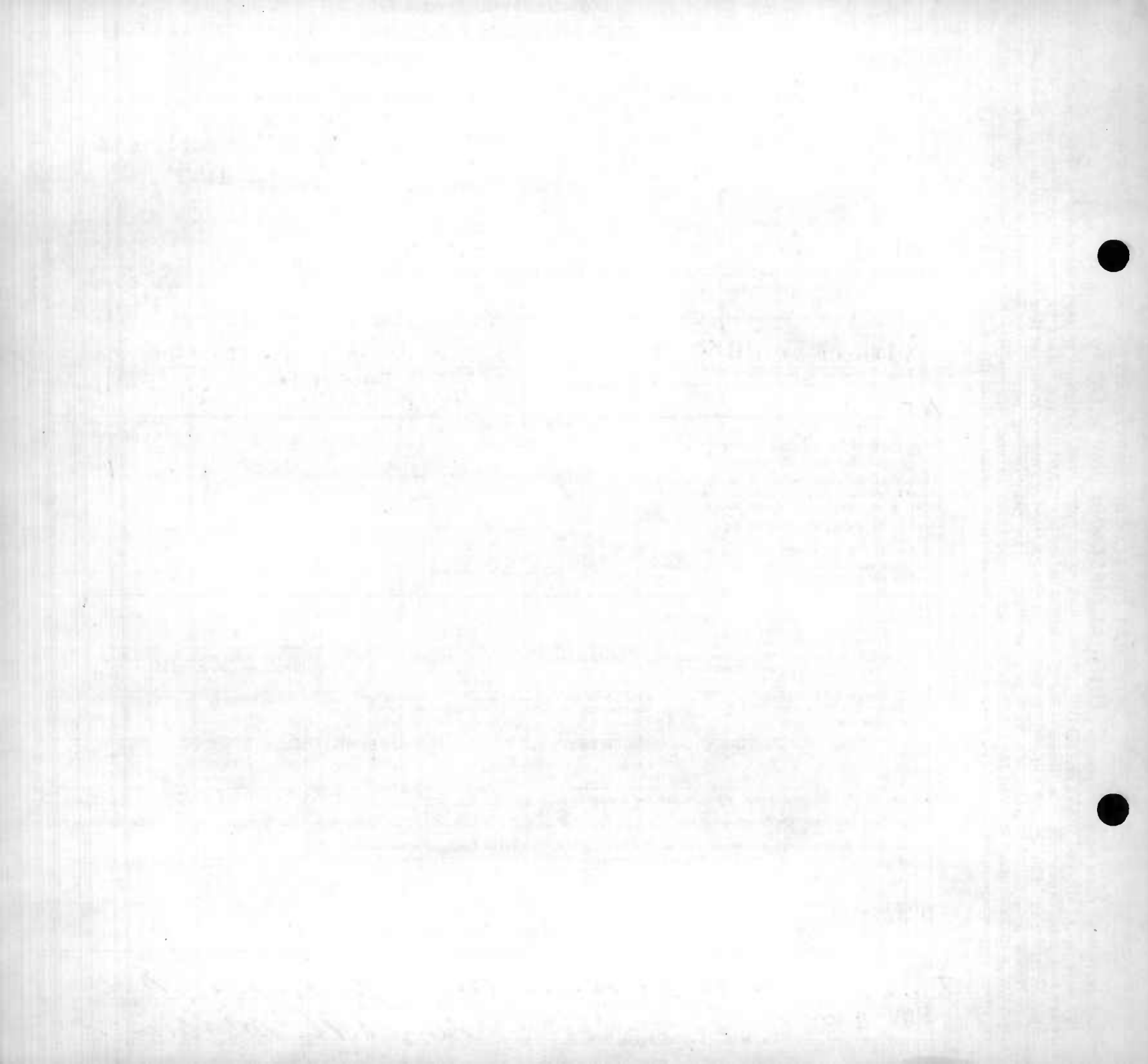
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# FUNERAL DIRECTOR: IMPORTANT

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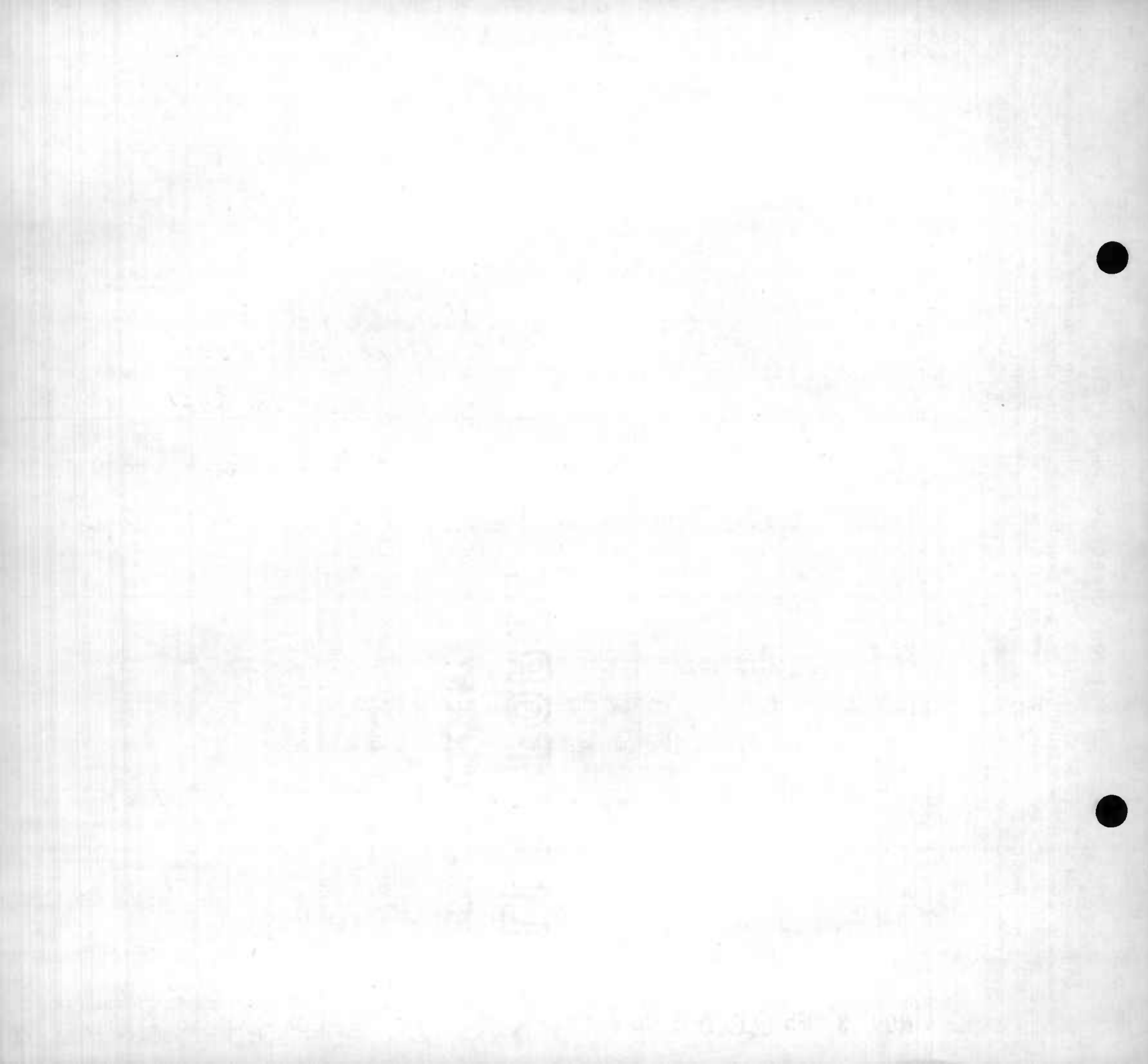
BIRTH NO. 65 11270		BALTIMORE CITY HEALTH DEPARTMENT 24-70-60		Registered No. 65 11270	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Thomas Williamson		2. DATE AND HOUR OF DEATH 11-2-65		8 20 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 17, Md.			
		D. STREET ADDRESS (If rural, give location) 13-03			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid.	8. DATE OF BIRTH 7/7/01	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Ret.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ga.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Solomon Williamson		14. MOTHER'S MAIDEN NAME MARY FRAZIER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT DAUGHTER VELMA MOSES - 2207 ELLAMONT STREET	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 433.01		CAUSE OF DEATH (A) DUE TO Cardiac Arrest.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-24-65 to 11-2-65, that (I) (we) last saw the deceased alive on 11-2-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rabul F. Waseel		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-2-65	
23C. PHYSICIAN'S NAME (Type) Rabul F. Waseel		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem.	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1965		25B. NAME OF REGISTRAR Robert E. Fagan		25C. FUNERAL DIRECTOR George A. Liber	
				ADDRESS 1348 N. Calhoun St	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO.		65 11271		CERTIFICATE OF DEATH		Registered No.		65 11271			
1. NAME OF DECEASED (Type or Print)				CORA LEE FALLIN				2. DATE AND HOUR OF DEATH 10-31-65				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Md.				B. COUNTY 15-01							
C. CITY OR TOWN BALTO.				D. STREET ADDRESS (If rural, give location)											
5. SEX F.				6. RACE C.				7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED				8. DATE OF BIRTH 7/23/85			
9. AGE (In years last birthday) 80				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				11. BIRTHPLACE (State or foreign country) VA.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME ? PALMER				14. MOTHER'S MAIDEN NAME MATILDA WILSON											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT COTENA WARRINGTON 2421 Woodbrook AV				ADDRESS			
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO Myocardial Degeneration				INTERVAL BETWEEN ONSET AND DEATH 2 wks							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Coronary Arteriosclerosis				2 wks							
(C) DUE TO															
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 5-19-65 19 to 10-31-65 19, that (I) (we) last saw the deceased alive on 10-31-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE G. Franklin Phillips				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 11/3/65							
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips				23D. ADDRESS 558 McNab St. Balt. Md.											
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 11/6/65				24C. NAME of CEMETERY or CREMATORY Rebeboth Church, VA.				24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1965				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				25C. FUNERAL DIRECTOR Joseph B. Locks, Jr.				ADDRESS 1304 R. Central Ave			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11272				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11272	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ROBERT AMOS</b>				2. DATE AND HOUR OF DEATH <b>11-2-65 2:40 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>10202</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1008 WILMOT COURT</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-3-94</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOHN AMOS</b>				14. MOTHER'S MAIDEN NAME <b>MARY MEYERS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Robert Raper</b>		ADDRESS <b>3530 Hilton Rd</b>	
18. <b>493X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>prob gm neg sepsis</b>				CAUSE OF DEATH (A) DUE TO <b>Overwhelming pneumonia, prob Pseudomonas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>prob stress ulcer &amp; terminal GI bleed</b>				(B) DUE TO		2 wks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0 5</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>0</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/14 1965</b> to <b>11/2 1965</b> , that (I) (we) last saw the deceased alive on <b>11/2 1965</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert I Keimowitz</b>				23B. DATE SIGNED <b>11/2/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Robert I Keimowitz</b>		23D. ADDRESS <b>Johns Hopkins Hosp</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-6-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>ARBUS MEM. PK</b>		24D. LOCATION (City, town, or county) (State) <b>ARBUS. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Joseph J. Rook</b>		ADDRESS <b>1304 N. Central Ave</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or at a place where the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 11273</u>	
BIRTH NO. <u>65 11273</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Berryl Smith</u>		2. DATE AND HOUR OF DEATH <u>6 25 AM 11/1/65</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>7-05</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1609 Milliman Street</u>			
5. SEX <u>female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>4-12-95</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>John Bailey</u>			14. MOTHER'S MAIDEN NAME <u>Louisa Cooper</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Ruth Nelson 223 Beale Ct</u>	
18. <u>5-87.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Pancreatitis</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>3/10/31/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Resp. diffie.</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> 19 <u>65</u> to <u>11/1</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>11/1</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Daniel G. Robinhold</u>				23B. DATE SIGNED <u>11/1/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>DAVID G. ROBINHOLD</u>				23D. ADDRESS <u>M.D. J.H.H.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/5/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	
24D. LOCATION (City, town, or county) <u>A. A. County MD</u>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Joseph H. Locks Jr 1304 N. Central Ave</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11274	
BIRTH NO. 65 11274		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) REGINA L. BECKER ALBERT		2. DATE AND HOUR OF DEATH 10/30/65 6:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-63		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 907 Chestnut Hill Avenue		D. STREET ADDRESS (If rural, give location) 907 Chestnut Hill Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 7, 1877	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Frederick Becker		14. MOTHER'S MAIDEN NAME Mary E. Braun	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Katherine Neville (Daughter)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Pulmonary edema Coronary arteriosclerosis and generalized arteriosclerosis 15 years		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Cerebral arteriosclerosis 15 years		INTERVAL BETWEEN ONSET AND DEATH 4 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 14 1961 to October 30 1965, that (I) (we) last saw the deceased alive on October 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard H. Tillman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov 1, 1965	
23C. PHYSICIAN'S NAME (Type) Richard Tillman		23D. ADDRESS M.D. 3025 St. Paul Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/65		24C. NAME OF CEMETERY or CREMATORY Cathedral Cem.	
24D. LOCATION City					
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home	
25D. ADDRESS 6500 York Rd.					

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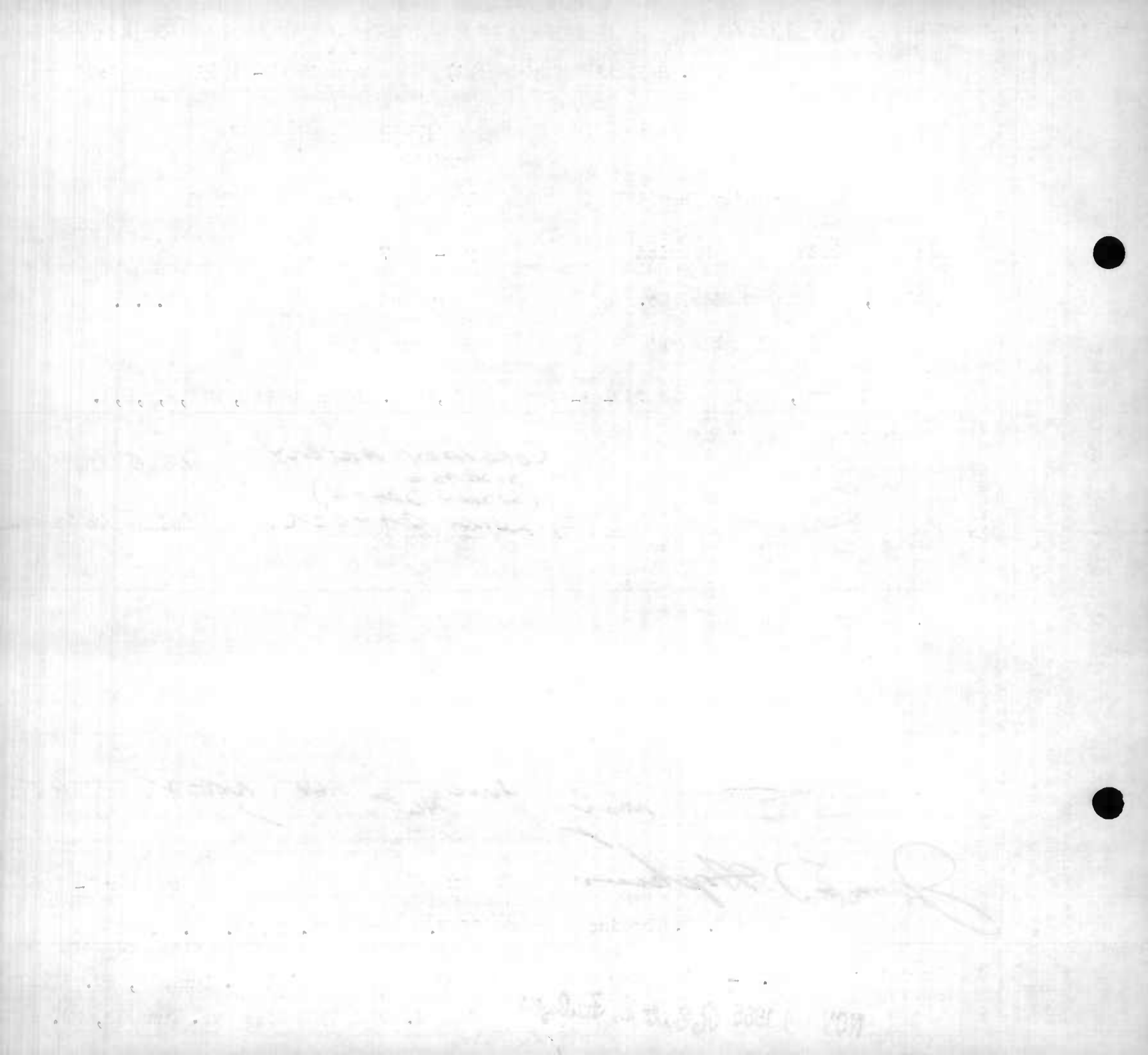
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11275</b>	
BIRTH NO. <b>65 11275</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>PHILIP Z. SEIBEL* (*Zyblewski)</b>	
2. DATE AND HOUR OF DEATH <b>November 2- 1965</b>		<b>5:05 pm</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
5. SEX <b>Male</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Dundalk</b>	
6. RACE <b>White</b>		D. STREET ADDRESS (If rural, give location) <b>8208 Beach Drive 21222</b>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		E. AGE (In years last birthday) <b>68</b>	
8. DATE OF BIRTH <b>May 1- 1897</b>		9. AGE (In years last birthday) <b>68</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Bethlehem Steel Co.</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Zyblewski</b>		14. MOTHER'S MAIDEN NAME <b>Anna Petza</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Navy Reserve, WW I</b>		16. SOCIAL SECURITY NO. <b>212-01-5950</b>	
17. INFORMANT <b>Wife, Mrs. Helen Seibel, # 4, a, b, c, d.</b>		ADDRESS	
18. <b>420.1-163X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY ARTERY DISEASE (SUDDEN DEATH)</b>		CAUSE OF DEATH (A) <b>CORONARY ARTERY DISEASE (SUDDEN DEATH)</b> (B) <b>LONG CANCER</b> (C)	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 1964</b> to <b>Nov 2 1965</b> , that (I) (we) last saw the deceased alive on <b>Nov 2 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>James E. T. Hopkins</b>		23B. DATE SIGNED <b>November 3- 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>James E. T. Hopkins</b>		23D. ADDRESS <b>205 W. Lanvale St. Balto. Md. 21202</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov. 6- 1965</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart of Mary</b>		24D. LOCATION (City, town, or county) (State) <b>German Hill Rd. Dundalk, Md. 21222</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>JOHN J. DUDA</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11276				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11276	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHN WILLIAM HILL</b>				2. DATE AND HOUR OF DEATH <b>11/2/65 2:05 AM</b>			
3. PLACE OF DEATH <b>IN BALTIMORE, MARYLAND</b> <b>Franklin Sq Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balts. 30</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balts. 30</b>			
				D. STREET ADDRESS (If rural, give location) <b>7101 Battery Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>9/17/05</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist - Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Balts., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John William Hill</b>				14. MOTHER'S MAIDEN NAME <b>Belle Condon</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Elinor Y. Hill</b>		ADDRESS <b>1101 Battery Ave.</b>	
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Branchiopneumonia</b>				CAUSE OF DEATH (A) DUE TO <b>Branchiopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Confluent</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pulmonary Edema</b>				(B) DUE TO <b>Pulmonary Edema</b>			
(C) DUE TO <b>Pulmonary Edema</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 25</b> 19 <b>65</b> to <b>Nov 2</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Nov 2</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Samuel B. Luecke</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Nov 2, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAMUEL B LUECKE</b>				23D. ADDRESS <b>Franklin Sq Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11 5 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, A. A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Mc Gully</b>		ADDRESS <b>130 E. Fort ave</b>	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11277				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11277	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BALL, ANNA				2. DATE AND HOUR OF DEATH 11-1-65 10:30AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) CATON RIDGE NURSING HOME			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-7-83	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ADOLPH WOLFE				14. MOTHER'S MAIDEN NAME Hermina Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKINS AND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH Fracture left Hip Congestive heart failure			
19A. DATE OF OPERATION O				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-15-65				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office-bldg., etc.) Murray Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 329 Parkview Lane	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR? fell in bathroom			
22. I certify that (I) (this hospital) attended the deceased from 9-15-19 65 to 11-1-19 65, that (I) (we) last saw the deceased alive on 11-1-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Steve C. Papastephanou				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-1-65	
23C. PHYSICIAN'S NAME (Type) STEVE C PAPASTEPHANOU				23D. ADDRESS M.D. ST AGNES HOSPITAL, BALTIMORE 29, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 4 1965		24C. NAME OF CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Mc Cully,		ADDRESS 130 E. Fort Ave	

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James J. [illegible]

12/2/65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11278	
BIRTH NO. 65 11278				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Ida, Baby Boy, Wynder				October 28, 1965   9:35 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224				A. STATE Maryland B. COUNTY 12-06	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 2817 Remington Avenue, #21211	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Newborn	8. DATE OF BIRTH 10-16-1965	9. AGE (In years last birthday) 12	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Smith		14. MOTHER'S MAIDEN NAME Ida Wynder	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., #21224	
18. 767.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Diarrhea & Dehydration DUE TO (B) Rule Out Salmonellosis DUE TO (C)	
INTERVAL BETWEEN ONSET AND DEATH 5-7 Days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 28, 19 65 to October 28, 19 65, that (I) (we) last saw the deceased alive on October 28, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Wayne Klein				23B. DATE SIGNED 10-28-65	
23C. PHYSICIAN'S NAME (Type) DR. S. WAYNE KLEIN				23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Md., #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11-2-65		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals Baltimore, Maryland 21224	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR ADDRESS		25D. FUNERAL DIRECTOR ADDRESS		25E. FUNERAL DIRECTOR ADDRESS	

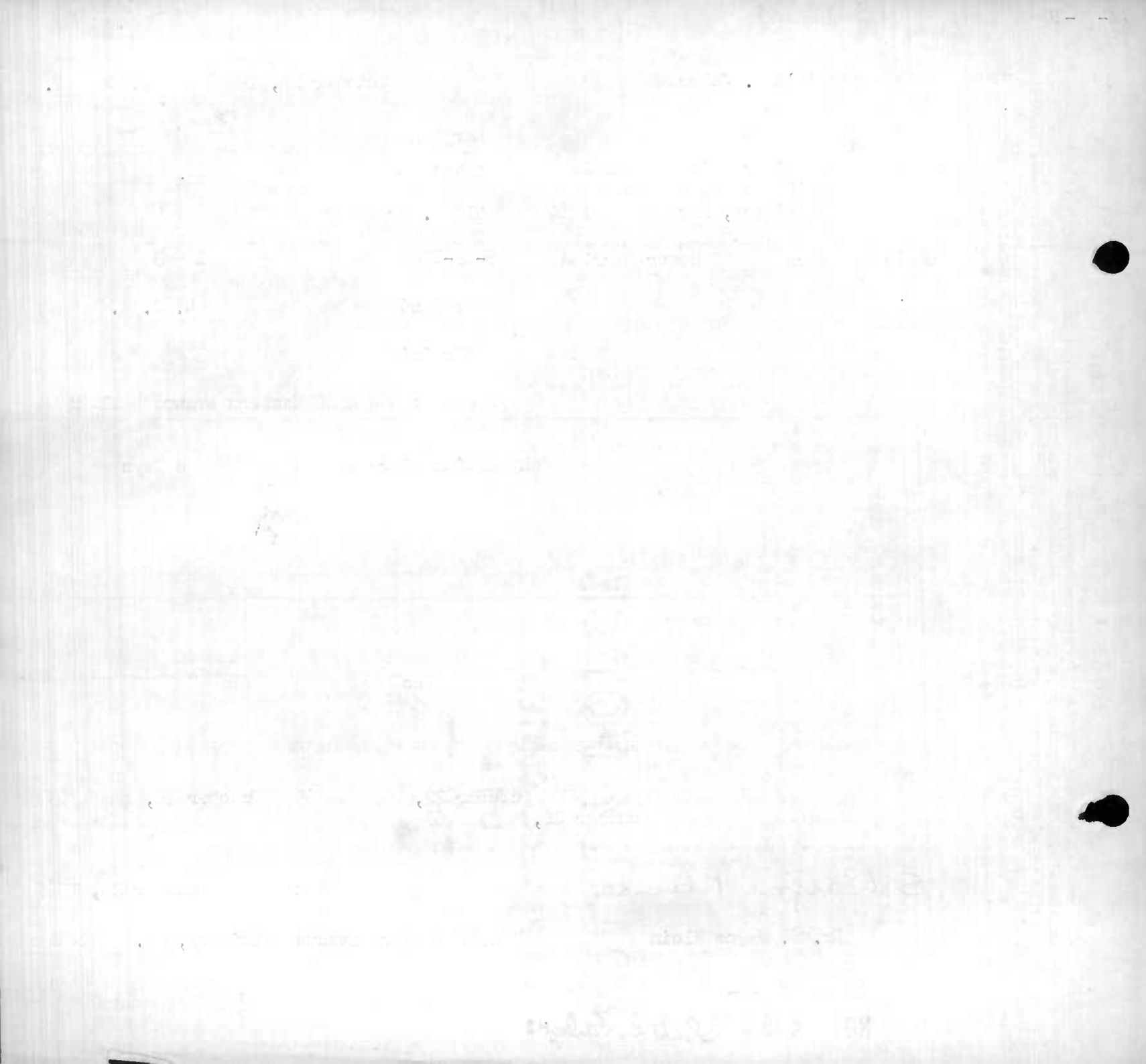
12/65 - Salmonella ruled out - inform from BCH  
see File - Bar. of Biosciences  
American Bldg 8c

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-11279		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11279	
1. NAME OF DECEASED (Type or Print) Virginia A. Johnson				2. DATE AND HOUR OF DEATH October 26, 1965 7:30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 815 N. Broadway 21205			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 9-23-1965	9. AGE (In years lost birthday) 1 3	If Under 1 Yr. Months Days Hours Min. 1 3	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Virginia			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS REC ORDS: BCH 4940 Eastern Avenue 21224			
18. 764.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Dehydration Diarrhea DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 Days	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from October 22, 19 65 to October 26, 19 65, that (I) (we) last saw the deceased alive on October 26, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Wayne Klein				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED October 26, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. S. Wayne Klein				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11-2-65		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospital		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65-27090</u> <u>65</u> <u>11280</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65</u> <u>11280</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby of Ozie Whitfield</u>		2. DATE AND HOUR OF DEATH <u>October 27, 1965</u> <u>8:04 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2125 Callow Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>10-26-65</u>	9. AGE (In years lost birthday) <u>1 1/2</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>1 1/2</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ozie Whitfield</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>762.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Immaturity</u> DUE TO (B) <u>Pulmonary atelectasis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 26, 1965</u> to <u>October 27, 1965</u> , that (I) (we) last saw the deceased alive on <u>October 27, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jose B. Covera, M.D.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>October 28, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Jose B. Covera</u>		23D. ADDRESS <u>1514 Division Street</u> <u>Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>NOV 2 1965</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATOR <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>	



# FUNERAL DIRECTOR: IMPORTANT

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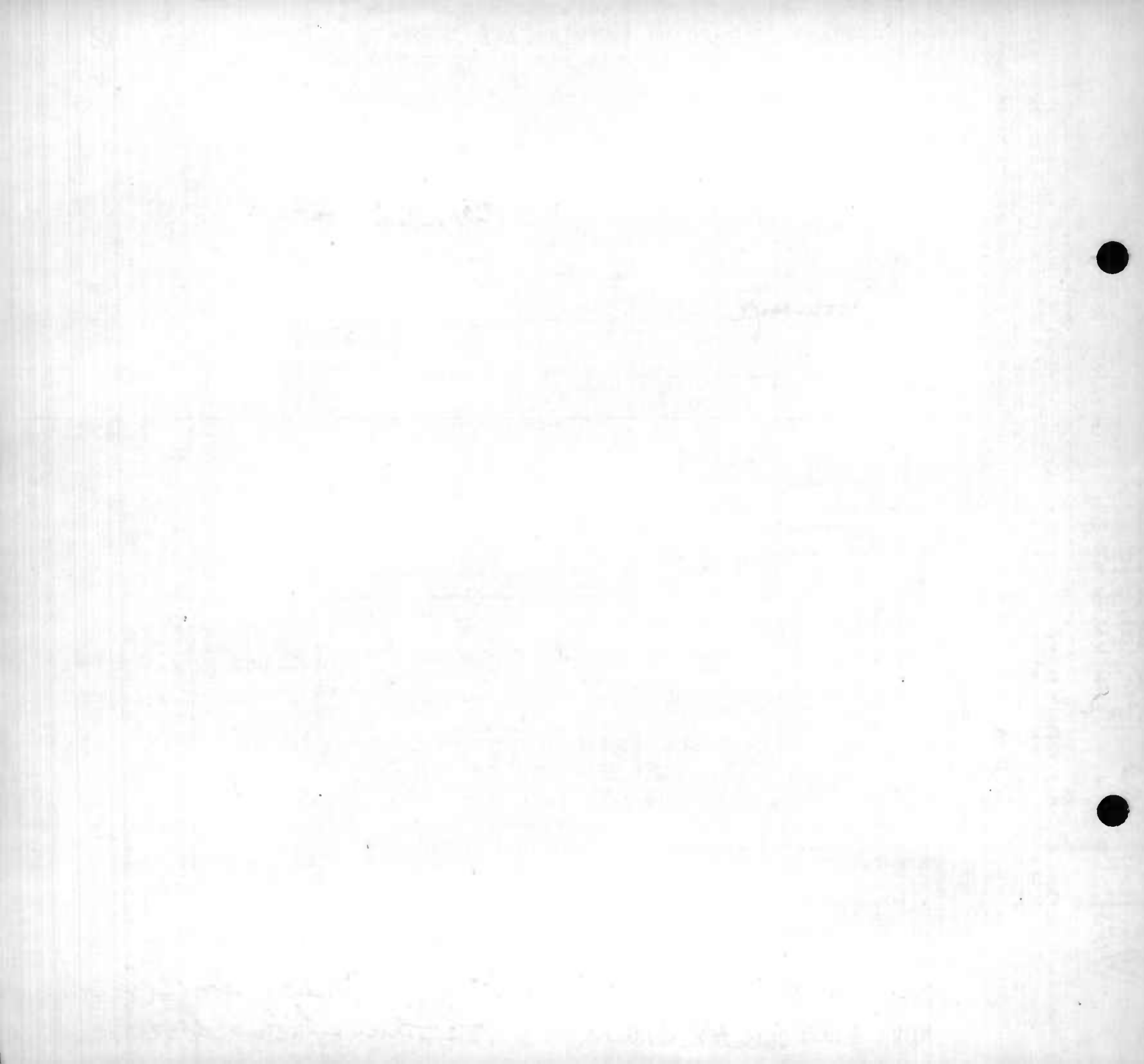
BIRTH NO. 65-21030 65 11281		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11281	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BENSER BABY BOY</b>		2. DATE AND HOUR OF DEATH <b>10-29-65 7.45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>12-06</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH Home AND Hospital</b>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>2202<sup>N</sup> Charles St.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>10-29-65</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>20</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>xx</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Francis Wells, Jr.</b>			14. MOTHER'S MAIDEN NAME <b>Roberta Benser</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>xx</b>	17. INFORMANT ADDRESS <b>Mother - 2202<sup>N</sup> Charles St.</b>		
18. <b>776 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>PREMATURITY - 25 weeks</b>		CAUSE OF DEATH (A) <b>Prematurity - 25 weeks</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>	
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 29 1965</b> to <b>Oct. 29 1965</b> , that (I) (we) last saw the deceased alive on <b>Oct. 29, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. William Dorman, Jr., M.D.</b>			23B. DATE SIGNED <b>10-29-65</b>		
23C. PHYSICIAN'S NAME (Type) <b>J. William Dorman, Jr.</b>			23D. ADDRESS <b>3101 St. Paul St. Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>NOV 2 1965</b>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>ANATOMY BOARD OF MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>	

George H. Moore

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 2em;">X</span>	
BIRTH NO. <span style="font-size: 2em;">65 11282</span>		CERTIFICATE OF DEATH			
M.E. CASE NO. <span style="font-size: 2em;">65 11282</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 2em;">11-2-65</span>   <span style="font-size: 2em;">1.40 A.M.</span>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">MATTIE SMALL</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.5em;">SOUTH CAROLINA</span> B. COUNTY <span style="font-size: 1.5em;">V-37</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">THE JOHNS HOPKINS HOSPITAL</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">MYRTLE BEACH</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.5em;">2621 Walnut Court SE</span>			
5. SEX <span style="font-size: 1.5em;">FEMALE</span>	6. RACE <span style="font-size: 1.5em;">NEGRO</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.5em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.5em;">2-28-23</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">42</span>	If Under 1 Yr. Months: Oays: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <span style="font-size: 1.5em;">QUINCY KNOX</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">CATHERINE</span>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <span style="font-size: 2em;">151X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <span style="font-size: 1.5em;">Carcinoma of stomach &amp; metastases</span> DUE TO (B) <span style="font-size: 1.5em;">Metastases</span> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">5 months -</span>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.5em;">3-10-22-65</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.5em;">Carcinoma of stomach</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">NO YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">10-13</span> 19 <span style="font-size: 1.5em;">65</span> to <span style="font-size: 1.5em;">11-2</span> 19 <span style="font-size: 1.5em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">11-2</span> 19 <span style="font-size: 1.5em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Bryan D. Lowery M.D.</span> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <span style="font-size: 1.5em;">11-2-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">BRIAN D. LOWERY</span>		23D. ADDRESS <span style="font-size: 1.5em;">JOHNS HOPKINS HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Buried</span>	24B. DATE <span style="font-size: 1.5em;">11-7-1965</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.5em;">Gordon Chapel Cent</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Conway South Carolina</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">NOV 4 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Taylor M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.5em;">Baltimore &amp; Hwy South Carolina</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-476 65 11283		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11283	
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED		5 PM 11/1/65	
1. NAME OF DECEASED (Type or Print)		LILLIAN ALLBRITTON		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
THE JOHNS HOPKINS HOSPITAL		BALTIMORE		D. STREET ADDRESS (If rural, give location)	
918 N. BOND ST.		B. DATE OF BIRTH		9. AGE (In years lost birthday)	
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				North Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Nathan Allbritton		Celia Edwards		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Willie Allbritton 13 Bond St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) CARDIAC ARREST		30 MIN	
ANTECEDENT CAUSES		(B) GRAM NEG SEPSIS		2 WKS.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) URINARY TR. INFECTION			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/1/1965 to 11/1/1965, that (I) (we) lost saw the deceased alive on 11/1/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Ashley T. Haase				11/1/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ASHLEY T HAASE		JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Buried		11-3-65		Mt Carmel Cmt	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Baltimore		Cheryl Wilson Wood Brantley			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
				Cheryl Wilson Wood Brantley	





65 11284

BALTIMORE CITY HEALTH DEPARTMENT

65 11284

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN ARTHUR GALLOP

2. DATE AND HOUR PRONOUNCED DEAD

11/2/65 1:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

1924 Linden Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO.

D. STREET ADDRESS (If rural, give location)

2219 Brookfield Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9-23-1914

9. AGE (in years  
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

Shipping

11. BIRTHPLACE (State or foreign country)

MAMIE, N. C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Moses Gallop

14. MOTHER'S MAIDEN NAME

Jazney Gallop

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Joseph Gallop

MAMIE, N. C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) FATTY LIVER  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

PARTIAL

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, lorn, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M. D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/2/65 DATE SIGNED

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-7-1965

23C. NAME of CEMETERY or CREMATORY

Pleasant Br.

23D. LOCATION

MAMIE

(City, town, or county)

N. C.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 4 1965

24B. NAME OF REGISTRAR

Robert E. Farkema

24C. FUNERAL DIRECTOR

MORTON + DyeTT

ADDRESS

1701 Laurens St.

WALLACE J. HOPKINS

1945-1946

2

2

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

65 11285

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

VICKIE C. MARKOWSKI

2. DATE AND HOUR PRONOUNCED DEAD

November 2, 1965 2:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

600 N. Hilton St.

29

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 6, 1905

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Louisiana

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. (If yes, give war or dates of service))

No

None

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Stephen Markowski

600 N. Hilton St.  
Baltimore, Md. 29

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Nov. 3, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

11/4/1965

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

New Iberia, Louisiana

24A. DATE REC'D BY HEALTH DEPT.

NOV 4 1965

24B. NAME OF REGISTRAR

Robert E. Fickel

24C. FUNERAL DIRECTOR

Wm. J. Dickner &amp; Sons

ADDRESS

Baltimore, Md. 17  
North 2nd Ave

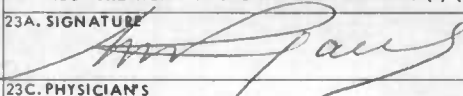
WALLLEY & DORR

MADE IN U.S.A.

WALLLEY & DORR

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11286				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11286	
M.E. CASE NO. 65 11286				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Blake, Dorothy</b>				2. DATE AND HOUR OF DEATH <b>11/1/65 9:25 p.m.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>17-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1235 Argyle Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11/30/11</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Johnson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-40-3334</b>		17. INFORMANT ADDRESS <b>Mr Bosley Blake 1235 Argyle Ave</b>			
18. <b>331X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Massive cerebral hemorrhage</b> DUE TO (B) <b>Hypertension</b> DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/1/65</b> 19 to <b>11/1/65</b> 19, that (I) (we) last saw the deceased alive on <b>11/1/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) <b>Dr. M. Rigaud</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-2-65</b>	
23D. ADDRESS <b>Provident Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/6/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

Maryland  
Baltimore  
1335 Argyle Ave.

Providence Hospital

11/30/11

Married

Negro

Female

Maryland

Massive cerebral hemorrhage

Hypertension

No

No

11/1/12

11/1/12

11/1/12

x

Providence Hospital

Dr. E. E. Rignand

NOV 1 1911



1  
W 425

65 11287

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11287

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) RUBY WILSON

2. DATE AND HOUR PRONOUNCED DEAD 10-31-65 6:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY 20-02  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore  
D. STREET ADDRESS (If rural, give location) 2301 Edmondson Avenue 21223

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL - DOA

5. SEX Female

6. RACE Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED

8. DATE OF BIRTH

9. AGE (in years last birthday) 36

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAY WORK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME MILTON BREADMON

14. MOTHER'S MAIDEN NAME ANNIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS MR THEODORE WILSON

18. 330X CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) ~~XXXX~~ Massive subarachnoid hemorrhage  
Originating from aneurysm of circle of Willis  
(B) DUE TO  
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.

DATE SIGNED 11-1-65

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL

23B. DATE 11/4/65

23C. NAME OF CEMETERY or CREMATORY National Cemetery

23D. LOCATION (City, town, or county) (State) BALTIMORE MD

24A. DATE REC'D BY HEALTH DEPT. NOV 4 1965

24B. NAME OF REGISTRAR Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR ADDRESS ADOLPHUS HALSTEAD 1206 W North Ave

VS 151-REV. 1/1/65

1-27

WALLACE BOB

WALLACE BOB

WALLACE BOB

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 6 65 11288				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11288	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH		A M.	
1. NAME OF DECEASED (Type or Print) John M. Stettmeier				11/3/65 6:40			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital				A. STATE B. COUNTY 314 Greenlow Rd. Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28			
				D. STREET ADDRESS (If rural, give location) 314 Greenlow Rd. 33-00			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4-25-85	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Butcher, Own business		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Stettmeier				14. MOTHER'S MAIDEN NAME Barbara			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218 36 0111		17. INFORMANT ADDRESS A-Mrs. Marie Bradburn, 314 Greenlow Rd			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY OCCLUSION DUE TO ARTERIOSCLEROTIC HEART DISEASE DUE TO DUE TO				INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-3-1965 to 11-3-1965, that (I) (we) last saw the deceased alive on 11-3-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Agustin del Campo M.D.				23B. DATE SIGNED 11-3 1965			
23C. PHYSICIAN'S NAME (Type) AGUSTIN DEL CAMPO M.D.				23D. ADDRESS Bon Secours Hosp. BALT. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 6/65		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Jankys		25C. FUNERAL DIRECTOR Witzke F.D.		25D. ADDRESS 4101 Edmondson Ave.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 11289					CERTIFICATE OF DEATH		Registered No. 65 11289		
1. NAME OF DECEASED (Type or Print) <i>Daisy M. Harden</i>					2. DATE AND HOUR OF DEATH <i>11-2-65 4:15 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hosp. of Baltimore, Md.</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ma.</i> B. COUNTY <i>28-41</i>				
5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>					8. DATE OF BIRTH <i>4-30-91</i>		9. AGE (In years last birthday) <i>74</i>		10. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired clerk,</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Hecht Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>late John Harden</i>					14. MOTHER'S MAIDEN NAME <i>late Mary E.</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>213 09 4487</i>		17. INFORMANT <i>Miss Bertha Harden, 3714 Mohawk Ave</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>E90401</i> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH <i>Bronchopneumonia</i> (A) <i>Due to</i> (B) <i>Fractured L Femur</i> (C) <i>Due to</i>				INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <i>10-14-65</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fr. L Femur</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>3714 Mohawk Ave Balto, Md.</i>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>Oct 6 1965</i>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Patient Fell 28-41</i>		
22. I certify that (I) (this hospital) attended the deceased from <i>10-2-65</i> to <i>11-2-65</i> , that (I) (we) last saw the deceased alive on <i>11-2-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Larry Becker, M.D.</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>11-2-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Larry Becker</i>					23D. ADDRESS <i>4924 Lanier Ave.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>11/5/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Landon</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 4 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Farley</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Witzke Funeral Dir - 4101 Edmondson</i>			

THE COURT

IN SENATE

AT THE CITY OF NEW YORK

IN SENATE

AT THE CITY OF NEW YORK

IN SENATE

IN SENATE

*Handwritten signature*

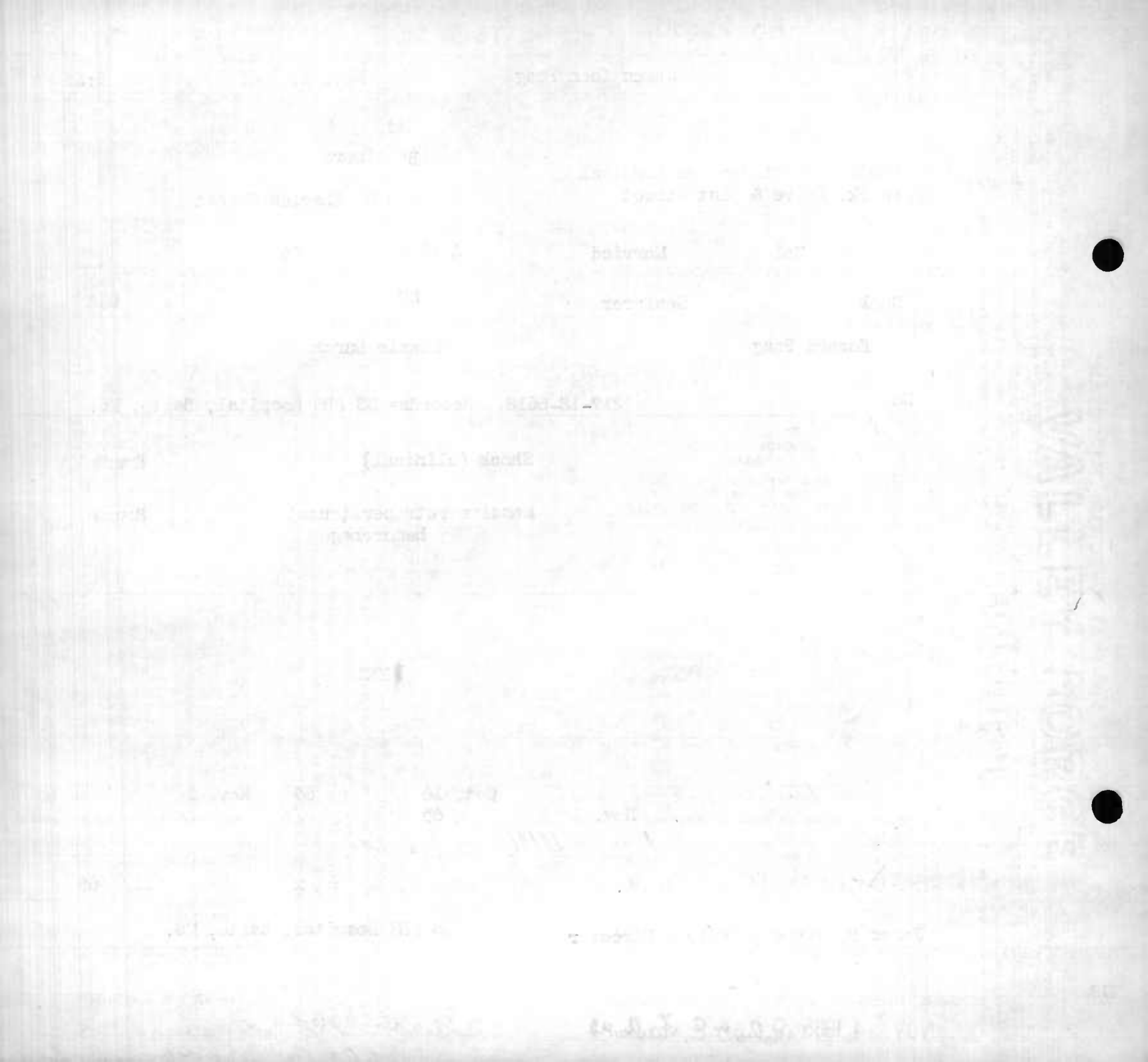


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11290		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11290	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		James Leon Poag		2. DATE AND HOUR OF DEATH Nov. 1, 1965 5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street		A. STATE Md. B. COUNTY 22-01		C. CITY OR TOWN Baltimore	
		D. STREET ADDRESS (If rural, give location)		708 S. Charles Street	
5. SEX M	6. RACE Col	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/11/09	9. AGE (In years lost birthday) 56	10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) NC	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Poag		14. MOTHER'S MAIDEN NAME Lizzie Burch	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-6618		17. INFORMANT Records= US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Shock (clinical)		Hours	
ANTECEDENT CAUSES		(B) Massive retroperitoneal hemorrhage		Hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from Oct. 16 19 65 to Nov. 1 19 65, that (X) (we) last saw the deceased alive on Nov. 1 19 65 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James M. W. Weaver		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/1/65	
23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-65		24C. NAME of CEMETERY or CREMATORY Mount Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore City		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Isaiah L. Brown & Son		25D. ADDRESS 105 W. Madison St.			





TO BE APPROVED BY MEDICAL EXAMINER

# FUNERAL DIRECTOR: IMPORTANT

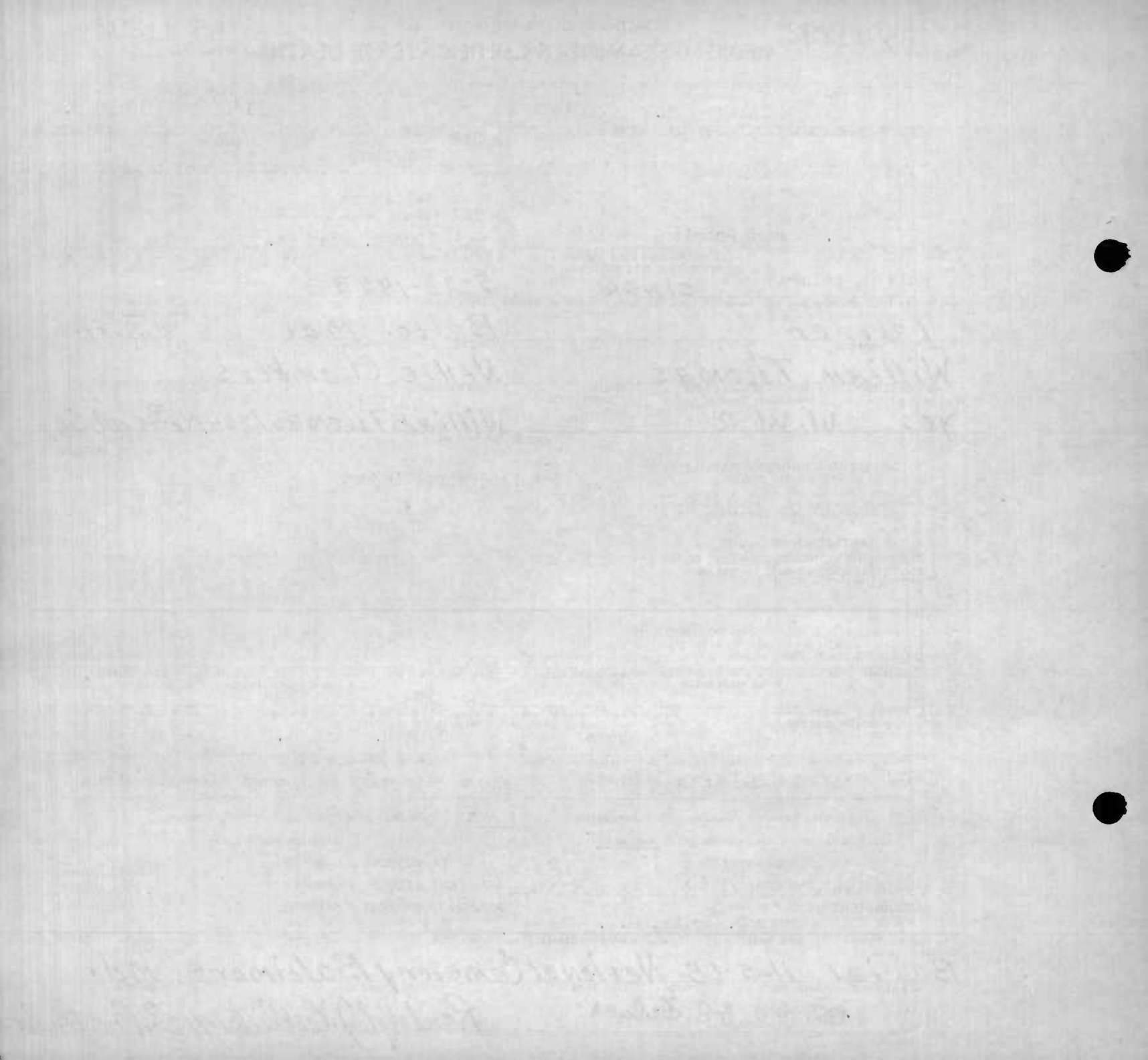
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 11291		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11291	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MISS SOPHIE DOGRAPSKI				2. DATE AND HOUR OF DEATH NOV 2 / 65 6:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 3-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 310 S. BROADWAY			
5. SEX F	6. RACE CAU	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8-2-05	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10B. KIND OF BUSINESS OR INDUSTRY STANDARD CAPT. MOLDING CO		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? RUSSIA	
13. FATHER'S NAME Stanislaw Pograpski				14. MOTHER'S MAIDEN NAME Pauline — LEWKO			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 37573		17. INFORMANT ANNA MELNICK Sister 8454 KAVANAGH RD		ADDRESS #22	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I MYOCARDIAL INFARCTION CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GANGRENE RT + LEFT TOES SECONDARY TO BURNS				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from NOV 2 1965 to NOV 2 1965, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. A. Tulentino				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/3/65	
23C. PHYSICIAN'S NAME (Type) MARIANO A. TULENTINO				23D. ADDRESS Church Home + Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV 6 65		24C. NAME OF CEMETERY or CREMATORY HOLY TRINITY CEM.		24D. LOCATION (City, town, or county) (State) ELK RIDGE MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Tulentino		25C. FUNERAL DIRECTOR Duffel Bros Inc		ADDRESS 1800 E LOMBARD ST	

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BIRTH NO. 65 11292		BALTIMORE CITY HEALTH DEPARTMENT		65 11292	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.					
1. NAME OF DECEASED (Type or Print) <b>WILLIAM H. THOMAS</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>11/1/65 10:30 p. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>St. Joseph Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>8-07</b> D. STREET ADDRESS (If rural, give location) <b>1206 N. Bond St.</b>		
5. SEX <b>male</b>	6. RACE <b>colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>single</b>	8. DATE OF BIRTH <b>5-23-1923</b>	9. AGE (In years last birthday) <b>42</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Thomas</b>			14. MOTHER'S MAIDEN NAME <b>Nellie Chambers</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>yes W.W. 2</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>William Thomas 1206 N. Bond St.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E900.0 I Craniocerebral injury</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1206 N. Bond St. 8-07</b>	
21D. TIME OF INJURY (APPROX.) <b>11 1 65 5:30p</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>allegedly fell down basement steps</b>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/2/65</b>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23B. DATE <b>11-5-65</b>	23C. NAME OF CEMETERY or CREMATORY <b>National Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1965</b>		24B. NAME OF REGISTRAR <b>Paul E. Farber, M.D.</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Randolph Collick 1412 E. Preston St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11293		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11293	
M.E. CASE NO.		CERTIFICATE OF DEATH		1	
1. NAME OF DECEASED (Type or Print) <b>Kirkwood LULA A</b>		2. DATE AND HOUR OF DEATH <b>11-2-65 8:25 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>515 ANNESLIE ROAD</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>2-6-89</b>	9. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		13. FATHER'S NAME <b>WILLIAM F. ANDERSON</b>		14. MOTHER'S MAIDEN NAME <b>ANN R. JACKSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>SAMUEL M. KIRKWOOD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>LYMPHO-SARCOMA</b> Generalized		INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-21-65</b> to <b>11-2-65</b> , that (I) (we) last saw the deceased alive on <b>11-2-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Agustin del Campo</b> M.D.				23B. DATE SIGNED <b>11-2-1965</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<b>AGUSTIN DEL CAMPO</b> M.D.				<b>BON SECOURS HOSP. BALT. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/5/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bethel Presbyterian</b>	
24D. LOCATION (City, town, or county) <b>Madonna</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11294		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11294	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Joseph H. Hebrank		2. DATE AND HOUR OF DEATH Nov. 1, 1965 4:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5115 Whiteford Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 10/21/1882	9. AGE (In years last birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maryland WorkShop For Blind Baltimore, Md.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Hebrank		14. MOTHER'S MAIDEN NAME Bernadine Willinger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-32-2780	17. INFORMANT Cyril H. Hebrank, Wyman Park Apt.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Myocardial infraction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 6, 1962 to Oct 1965, that (I) (we) last saw the deceased alive on 4-13-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. K.A. Peter VanBerkum		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/2/1965	
23C. PHYSICIAN'S NAME (Type) Dr. K.A. Peter VanBerkum		23D. ADDRESS 100 W. University Pkwy.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/1965		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 11295		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		65 11295	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
BETTY B. ANDREWS				11/3/65 12:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY					
44 UNION MEMORIAL HOSP				MARYLAND 27-14					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				BALTO					
				D. STREET ADDRESS (If rural, give location)					
				116 WOODLAWN RD					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
FEMALE	WHITE	MARRIED	3-9-26	39					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE			OWN HOME			MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
HAS W MITCHELL CHAMBER, JR				NANNIE D DALLAN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
NO			217-24-7187		MR FRANK ANDREWS		S/A		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO					
				RESPIRATORY FAILURE					
ANTECEDENT CAUSES				(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CHRONIC ASTHMA				21 YRS	
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from 10/17 19 65 to 11/3 19 65, that (H) (we) last saw the deceased alive on 2:30 AM 11/3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
ROBERT N. WHITLOCK				11/3/65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
ROBERT N. WHITLOCK				UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Cremation		11/3/1965		Greenmount		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 4 1965		Robert E. Jenkins		H.W. Jenkins & Sons Co.		4905 York Rd. Baltimore 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 11296		CERTIFICATE OF DEATH		65 11296	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		EDWARD H. GEBAUER (Edward H. Gebauer)		11/3/65 9:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
UNION MEMORIAL HOSPITAL		MARYLAND		BALTIMORE	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE		27-12	
		D. STREET ADDRESS (If rural, give location)			
		5106 SPRINGLACE WAY			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE	MARRIED	10/24/82	83	RETIRED - RECTIFIER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
		CROSS & BLACKWELL	WISCONSIN	USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
EDWARD H. GEBAUER			WILHELMINA BOLTER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT (MRS. C. H. PINKERTON) ADDRESS	
NO UNKNOWN			814-18-2140	DAUGHTER SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
420.01			(A) CONGESTIVE HEART FAILURE		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			DUE TO		
ANTECEDENT CAUSES			(B) Arteriosclerotic heart disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO		
			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/7/65 19 to 11/3/65 19, that (I) (we) last saw the deceased alive on 11/3/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Walter T. Boone				11/3/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WALTER T. BOONE		UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/6/1965		Druid Ridge	
24D. LOCATION (City, town, or county)		24E. STATE			
Pikesville, Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 4 1965		Robert E. Farley		H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.	

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

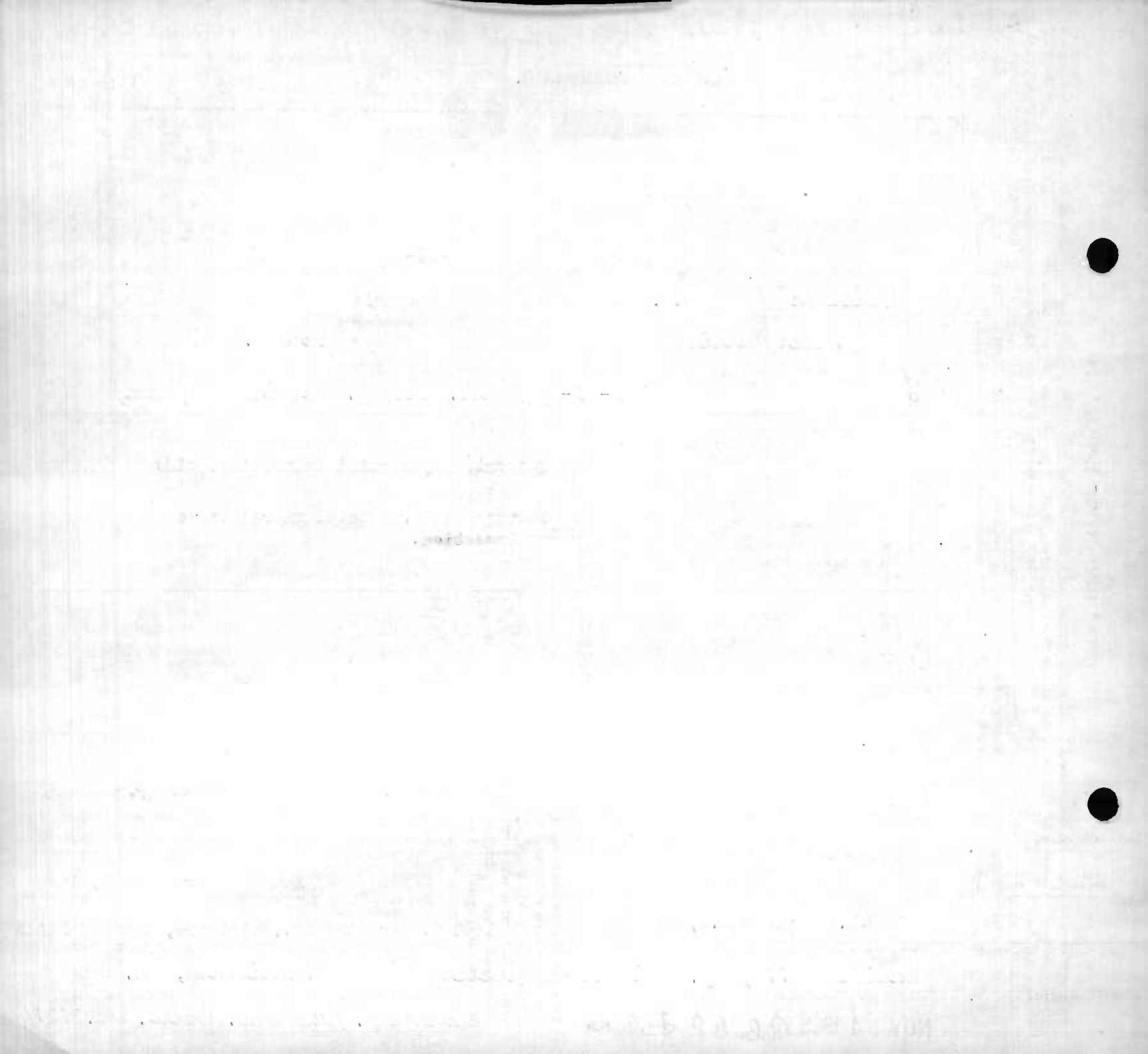
WYOMING

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11297				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11297	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				MARTIN, CLEOPHAS C.		November 2, 1965 11:40pm M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
St. Joseph Hospital				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 21220		53-00	
				D. STREET ADDRESS (If rural, give location)			
				9723 Matzon Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
Male	White	Married	10-12-13	52			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Salesman		W.P. Ihrie & Son		Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Peter Martin				Lura B. ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		228-07-7593		Mrs. Lucy E. Martin		(Same)	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) Posterior myocardial infarction, old.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Status post artificial mitral valve insertion.			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from		October 25, 19 65 to November 2, 19 65					
that (I) (we) last saw the deceased alive on		November 2, 19 65		and that in (my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
D.R. Govinda Rao,						November 3, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
D.R. Govinda Rao,				1400 N. Caroline St., Baltimore, Maryland 21213			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/7/65.		Birchlawn Cemetery		Pearisburg, Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 4 1965		Robert E. Farley, Jr.		Leonard J. Ruck Inc. Balto. Md. 21214			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

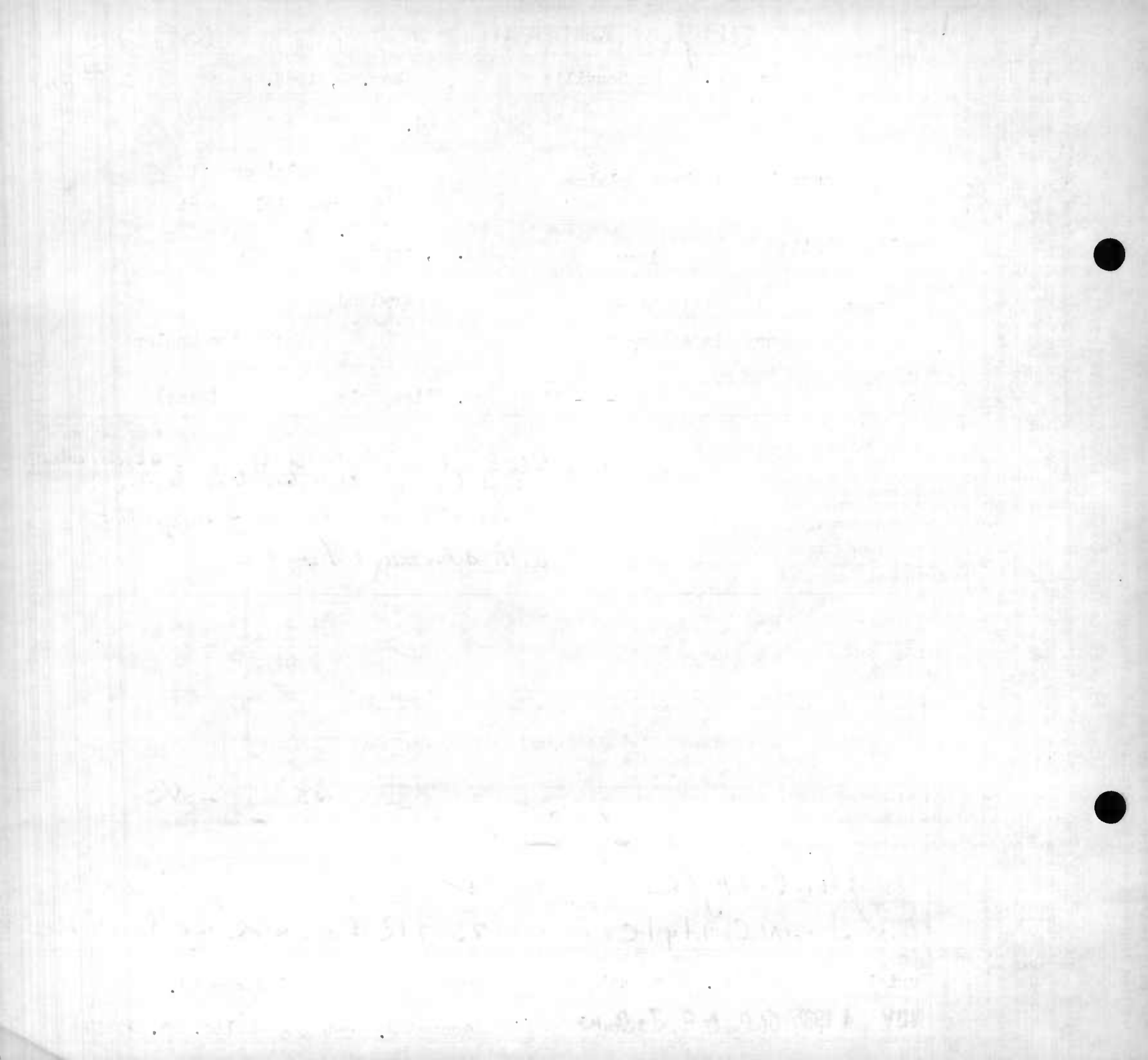
BIRTH NO. 65 11298				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11298	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HERMAN J. REIBETANZ, Sr.				2. DATE AND HOUR OF DEATH 10/30/65 8:10pm			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 UNION MEMORIAL HOSPITAL				A. STATE B. COUNTY MARYLAND USA 2705			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 14				D. STREET ADDRESS (If rural, give location) 3109 N. Ashland PK WAY			
5. SEX M.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-11-84	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ARTHUR REIBETANZ				14. MOTHER'S MAIDEN NAME ELIZABETH REIBETANZ Nee: Schmidt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212100794		17. INFORMANT Mr. Ernest H. Reibetanz, Same			
18. 422.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY OEDEMA Cadio Vascular Accident ↓				INTERVAL BETWEEN ONSET AND DEATH 10/28/65			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 10/30/65 (2 days)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 10/28/65 19 to 10/30/65 19 that (I) (we) last saw the deceased alive on 10/30/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Godfrey Geh				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/30/65	
23C. PHYSICIAN'S NAME (Type) GODFREY GEH, M.D.				23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/3/65		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., Balto., Md. 21214			

1.1.1.3 300000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11299		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11299	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		Eva M. Mc Conville		2. DATE AND HOUR OF DEATH Nov. 2, 1965. 2:45 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE Md.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
House in the Pines Belaire				Baltimore #12	
D. STREET ADDRESS (If rural, give location)		1302 Crownfield Court			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 1885 Aug. 2, 1965	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk		5&10 Store		Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Linderberger		14. MOTHER'S MAIDEN NAME Katherine Euhler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-22-9137		17. INFORMANT Mrs. Alice Hyle (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I INTERVAL BETWEEN ONSET AND DEATH several wks.		CAUSE OF DEATH (A) Cerebral emboli - mult. fcl. with left middle cerebral art. occlusion (B) Atherosclerotic Cardiovasc. Dis. (undet.) (C) with Anterior mural Thrombus.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1953 to 2 Nov 1965, that (I) (we) last saw the deceased alive on 1 Nov 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Hyle		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 2 Nov 65	
23C. PHYSICIAN'S NAME (Type) JOHN C. Hyle		23D. ADDRESS 7527 Belair Rd Balto 36 Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/65.		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11300		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11300	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>VINCENZA LUPPINO</b>		2. DATE AND HOUR OF DEATH <b>11/2/65 11:30 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>26-03</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #13</b>			
		D. STREET ADDRESS (If rural, give location) <b>3801 Belair Road</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10-16-<del>65</del> 92</b>	9. AGE (In years lost birthday) <b>73</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Sicily</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Sicily</b>		13. FATHER'S NAME <b>Carmelo Genna</b>			
14. MOTHER'S MAIDEN NAME <b>Rosalie Possalagua</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-36-7796</b>		17. INFORMANT <b>Mr. Jack Luppino</b>			
ADDRESS <b>(Same)</b>					
18. <b>292.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>CARDIAC ARREST</b> DUE TO (B) <b>MASSIVE BLEEDING</b> DUE TO (C) <b>APLASTIC ANEMIA</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>DRUG SENSITIVITY</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/24/65</b> to <b>11/2/65</b> , that (I) (we) last saw the deceased alive on <b>11/2/65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Huan</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/2/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>ASHLEY HARPER</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/6/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>	
ADDRESS <b>21214</b>					





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65-27877		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11301	
M.E. CASE NO. 65 11301		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby CLEMENS (Paula)		2. DATE AND HOUR OF DEATH 11/1/65 2 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital Pulaski Balto Sts.		A. STATE Md. 8. COUNTY 9-04			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2703 Greenmount Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NM Single	8. DATE OF BIRTH 11/1/65	9. AGE (In years last birthday) 1	If Under 1 Yr. Months: 0 Days: 0 If Under 24 Hrs. Hours: 1 Min. 40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Edward E. Clemens Jr			
14. MOTHER'S MAIDEN NAME Concetta Meyls		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Edward E. Clemens (Same)			
18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Immediate (B) Due to (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/1/65 to 11/1/65, that (I) (we) last saw the deceased alive on 11/1/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chong Kyu Bae		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/1/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/3/65		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Paul E. Fadden		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214	



65 11302

BALTIMORE CITY HEALTH DEPARTMENT

65 11302

BIRTH NO. 65-10380 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

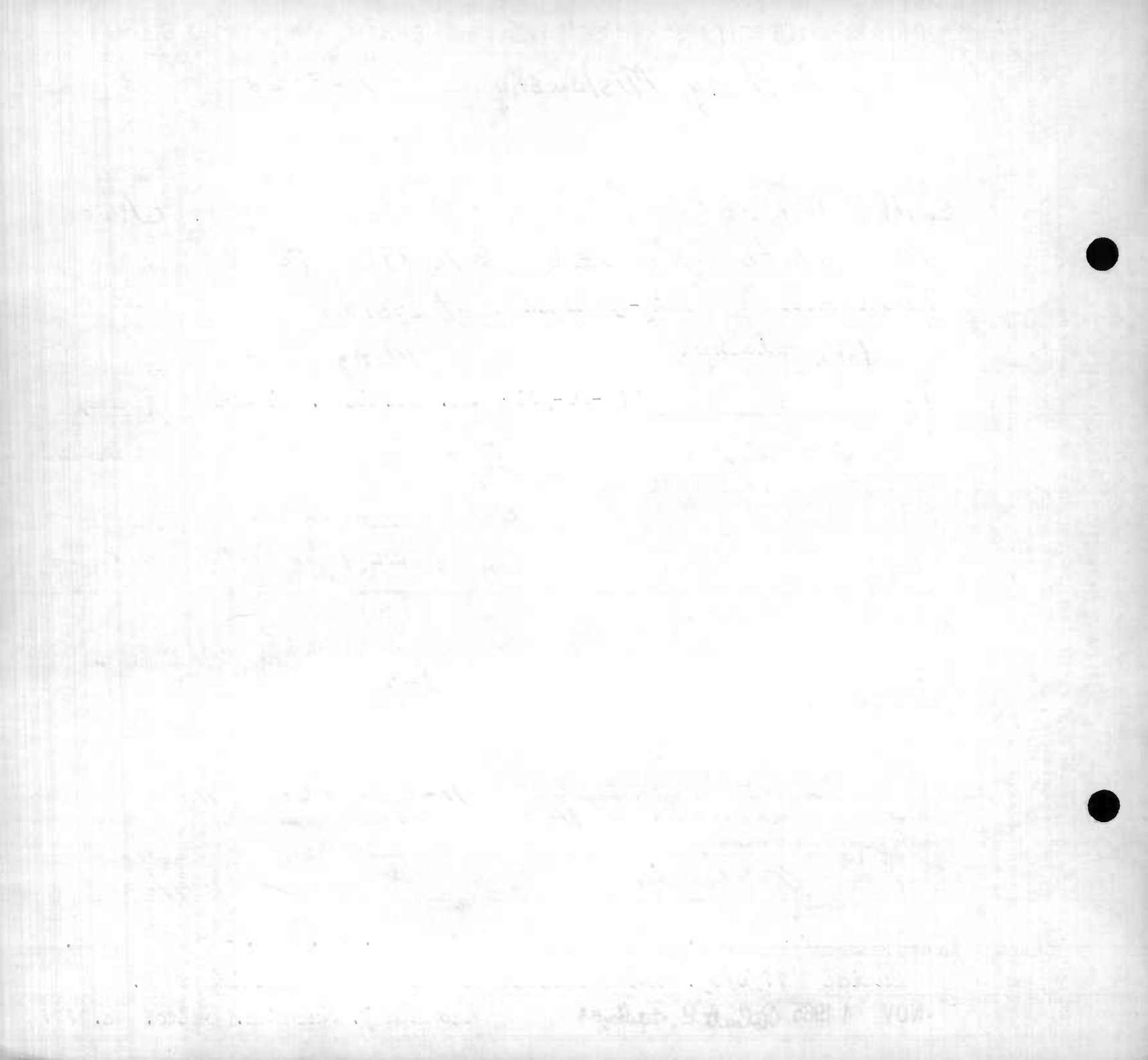
1. NAME OF DECEASED (Type or Print) <b>SEAN (SHAWAN) A. REALE</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>11/2/65 9:23 a.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4323 Hamilton Ave.</b>	
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>May 2, 1965</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>6</b>
13. FATHER'S NAME <b>Anthony F. Reale</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>
14. MOTHER'S MAIDEN NAME <b>Margaret A. Lochbaum</b>		17. INFORMANT <b>Mr. Anthony Reale,</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Interstitial pneumonitis</b> INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION <b>2</b>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20B. IF YES, WERE FINDINGS CONSIDERED IN CAUSING CAUSES OF DEATH? <b>yes</b>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>11/4/65</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
24C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., Balto., Md. 21214</b>		ADDRESS	

WALTER V. POIRCE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 11303		CERTIFICATE OF DEATH		65 11303	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Anthony Mislowsky		11-3-65 12:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		27-34	
South Baltimore General Hosp.		Baltimore #21206			
D. STREET ADDRESS (If rural, give location)		5810 Benton Height Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months; Days
M.	White	Married	6-16-1889	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country)	
Tavern Owner		Self-Employed		Russia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Mislowsky		Mary ?		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		216-18-7168		Mrs. Bessie A. Mislowsky	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Septicemia		48 hrs.	
ANTECEDENT CAUSES		(B) Urinary retention		unknown	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Carcinoma of prostate		unknown.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 11-2-19 65 to 11-3-19 65, that (we) last saw the deceased alive on 11-3-19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
DR. DAVID M. LANPHEAR				11-3-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		South Balto. Gen. Hosp. - 1213 Light St.			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/6/65		Holy Redeemer Cemetery	
24D. LOCATION		24E. (City, town, or county) (State)			
Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 4 1965		Robert E. Fairbank		Leonard J. Ruck Inc. Balto. Md. 21214	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 11304		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11304	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GILLARD, HOWARD, C.		10-31-65		2:12 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
ST. AGNES HOSPITAL		MARYLAND Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE 21228 Catonsville			
		D. STREET ADDRESS (If rural, give location)			
		1610 FREDERICK RD.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	MARRIED	8-3-94	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED LETTER CARRIER POST OFFICE DEPT MARYLAND				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
THOMAS GEORGE GILLARD		JANE KENNARD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES WORLD WAR 1		NONE		ST. AGNES HOSPITAL RECORDS WILKENS & CATON AVE. - 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I		(A) DUE TO		Sept 1 - 1965 to Oct. 31 - 1965	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-16-19 65 to 10-31-19 65, that (I) (we) last saw the deceased alive on 10-31-19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
DR. CARL H. MATTHEY		10-31-65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. CARL H. MATTHEY		ST. AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11/3/1965		BALTIMORE NATIONAL CEM.	
				BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 4 1965		Robert E. Farber		Easton Funeral Home CATONSVILLE MD.	



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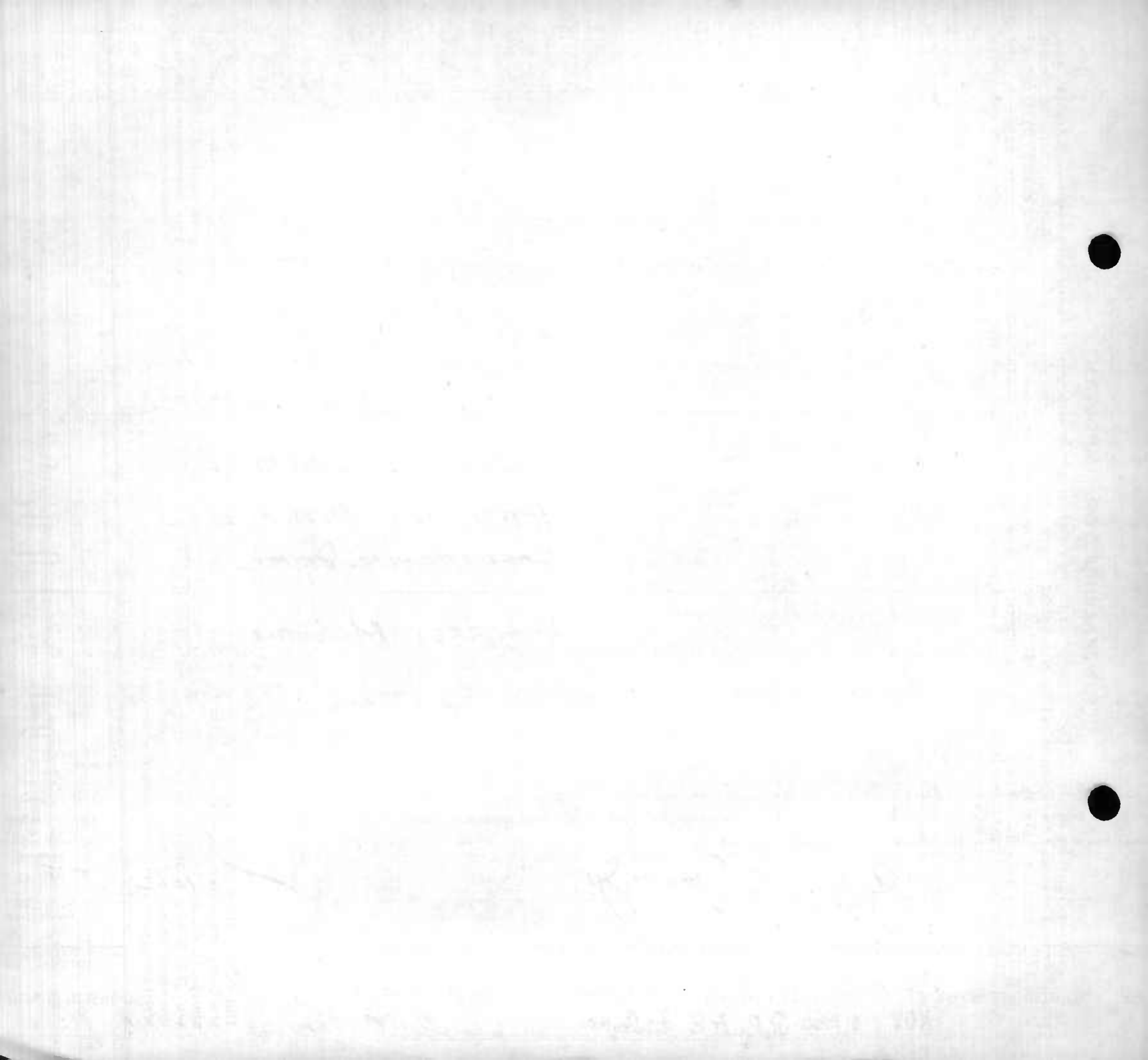
CHARTER

CHARTER

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

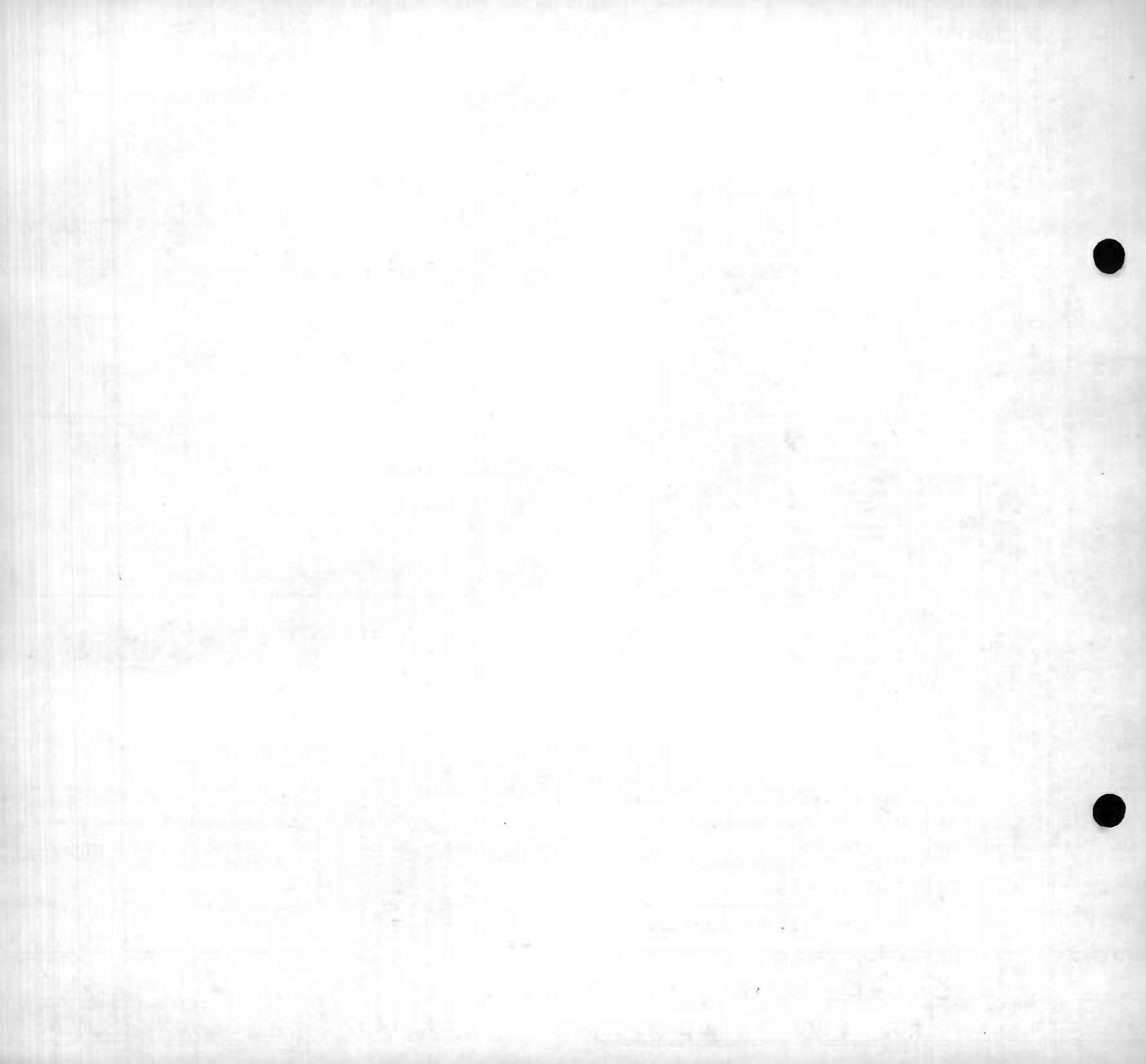
BIRTH NO. 65 11305				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11305	
M.E. CASE NO. Lady Webster				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LADY WEBSTER.				2. DATE AND HOUR OF DEATH November 2, 1965 8:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 13-08	
SOUTH BALTO GENERAL HOSP				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location)				3537 BUENA VISTA AVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH FEB 18, 1910	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME SAMUEL COUSIN				14. MOTHER'S MAIDEN NAME MELINDA McCAULEY.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				RAYMOND WEBSTER-3537 BUENA VISTA AVE			
18. 443 X 1 260 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) CEREBRAL INFARCTION			
ANTECEDENT CAUSES				(B) HYPERTENSIVE ARTERIOSCLEROTIC			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) CARDIOVASCULAR DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				DIABETES MELLITUS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10/22/1965 to 11/2/1965, that (I) (we) last saw the deceased alive on 11/2/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Calvin E. Jones, Jr. M.D.				23B. DATE SIGNED 11/2/65			
23C. PHYSICIAN'S NAME (Type) CALVIN E. JONES, JR. M.D.				23D. ADDRESS 1213 Light St. Balto Md 21230			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/65		24C. NAME OF CEMETERY or CREMATORY Lake View Memorial Park		24D. LOCATION (City, town, or county) Liberty Rd, Md. (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR		ADDRESS	
				Christen E. Donovan		3518 Roland Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11306		CERTIFICATE OF DEATH		Registered No. 65 11306	
1. NAME OF DECEASED (Type or Print) ROSE MARY CALLERY				2. DATE AND HOUR OF DEATH 11-2-65 2:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 13-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 3805 PLEASANT PLACE					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 10-19-13	9. AGE (In years last birthday) 52	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MATRON		10B. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME HARRY GOLDNER				14. MOTHER'S MAIDEN NAME GERTRUDE KLIGMAN					
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT HOSPITAL RECORD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 170X 1 260X				CAUSE OF DEATH (A) CARCINOMA OF BREAST DUE TO				INTERVAL BETWEEN ONSET AND DEATH 3 YRS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				DIABETES MELLITUS				2 YRS.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that, (H) (this hospital) attended the deceased from 3-29 19 65 to 11-2 19 65, that (H) (we) last saw the deceased alive on 11-2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Irving L. Cooperstein				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-2-65			
23C. PHYSICIAN'S NAME (Typed) Irving L. Cooperstein				23D. ADDRESS MONTEBELLO STATE HOSPITAL, BALTO. MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/65		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Old Frederick Rd, Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1965		25B. NAME OF REGISTRAR R. L. E. F. J. J. J.		25C. FUNERAL DIRECTOR Austin E. Donovan 3818 Federal Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11307</b>	
BIRTH NO. <b>65 11307</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIE BODDIE</b>		2. DATE AND HOUR OF DEATH <b>10/30/65 16:55 P.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>15-10</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hosp. of Balto. Inc.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21207</b>			
		D. STREET ADDRESS (If rural, give location) <b>4015 Maine Av.</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>11/30/85</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - formerly a porter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT Sears Roebuck</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>LEVI BODDIE</b>		14. MOTHER'S MAIDEN NAME <b>MARY (BUNN?)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT (Daughter) <b>Lillian Thomas</b> ADDRESS <b>4015 Maine Av.</b>	
18. <b>4201 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrhythmias</b>		CAUSE OF DEATH (A) DUE TO <b>Anterior</b> (B) DUE TO <b>Acute myocardial infarct</b> (C) <b>Arterio-Sclerotic Cardio-Vascular &amp; renal disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 1 MONTH</b> <b>1 MONTH</b> <b>&gt; 15 yrs.</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Fractured 9<sup>th</sup>, 10<sup>th</sup> &amp; 11<sup>th</sup> right ribs + 3/4 mos</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No</b>	
21D. TIME OF INJURY (APPROX.) <b>No</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>we</b> (this hospital) attended the deceased from <b>9/25/65</b> to <b>10/30</b> 19 <b>65</b> . that <b>we</b> (we) lost saw the deceased alive on <b>10/30</b> 19 <b>65</b> and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>we</b> (We) (did) <b>not</b> view the body after death.					
23A. SIGNATURE <b>Joseph A. Weinstein</b> M.D.				23B. DATE SIGNED <b>10/30/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sinai Hosp. of Balto. Inc.</b>		23D. ADDRESS <b>Laurel Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov. 3, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem. Park</b>	
24D. LOCATION (City, town, or county) <b>Laurel</b>		24E. STATE <b>Md.</b>		24F. DATE REC'D BY HEALTH DEPT. <b>NOV 4 1965</b>	
25A. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Brook J. Chilton - 112977</b>	
25D. ADDRESS <b>112977</b>					

10/10/05

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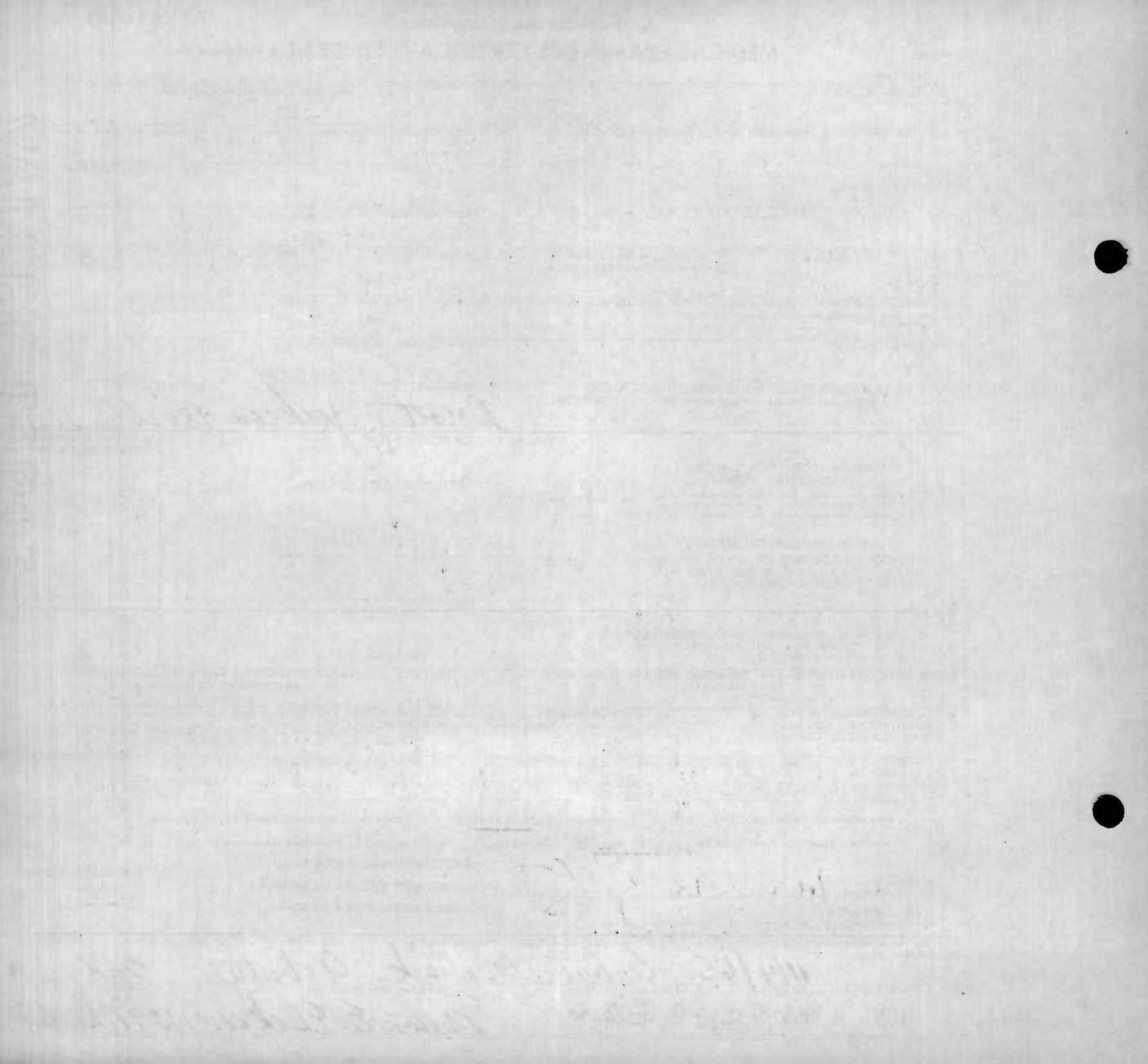
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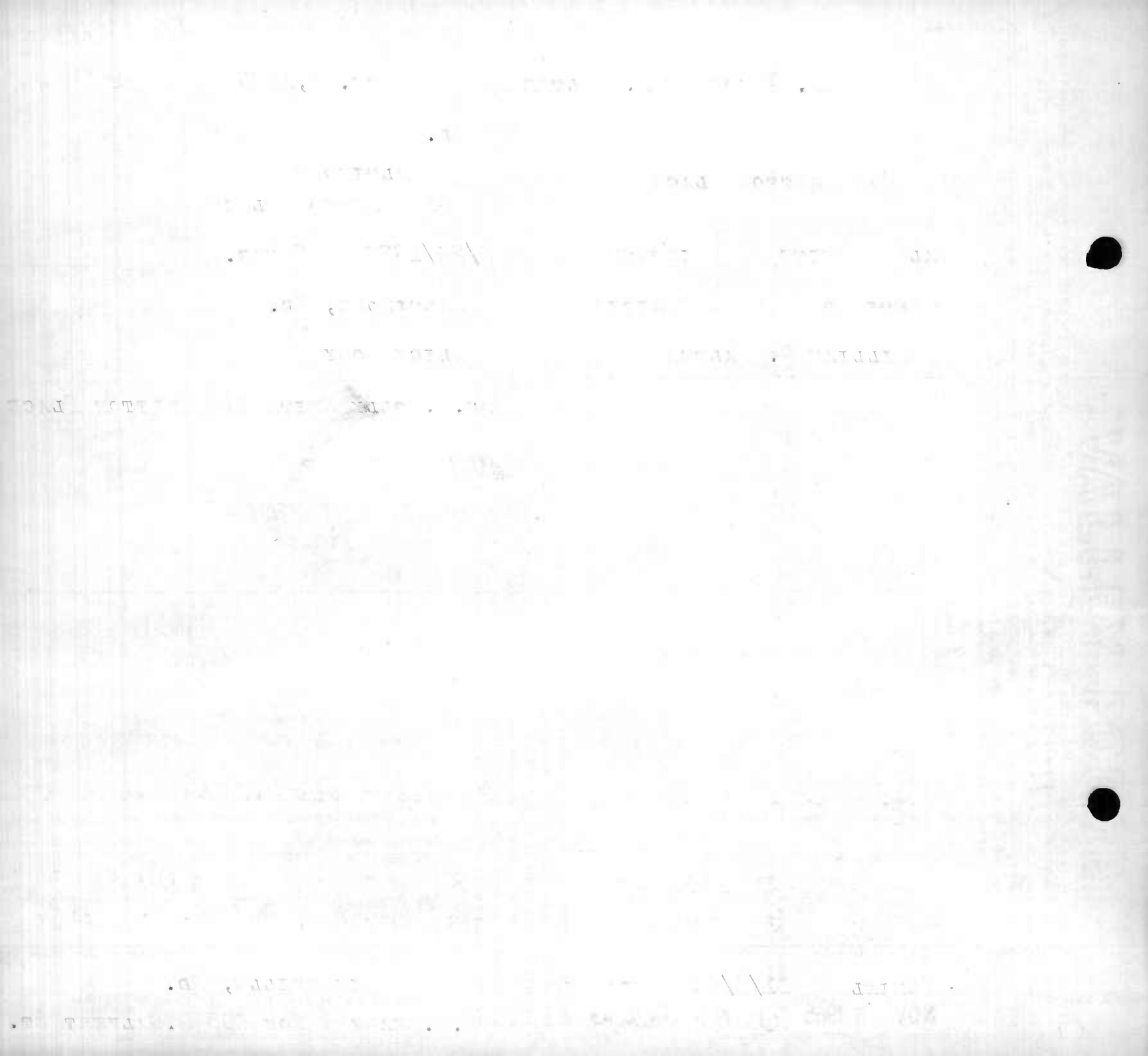
BIRTH NO. 65 11308		BALTIMORE CITY HEALTH DEPARTMENT		65 11308	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. _____	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD	
LEROY JACKSON				11-1-65 12:03 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
UNION MEMORIAL HOSPITAL - DOA				Maryland	
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
				Baltimore	
				D. STREET ADDRESS (If rural, give location)	
				4802 Alhambra Avenue 21212	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Colored	Single	Dec. 18, 1943	21	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Photographer NSA			Balt. Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Leroy Jackson			Dorothy Fees		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Dorothy Jackson 4802 Alhambra Ave.
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Multiple injuries	
ANTECEDENT CAUSES				(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Street		At Winston Avenue Gate of Loyola College	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour) (Minute)		(Hour) (Minute) WHILE AT WORK NOT WHILE AT WORK		Driver of auto into fixed object	
10 31 '65 11:30 PM		WHILE AT WORK NOT WHILE AT WORK			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)				23D. LOCATION (City, town, or county) (State)	
Burial				Arbutus Md.	
23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23E. DATE SIGNED	
11/4/65		Arbutus Memorial Park		11-1-65	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
NOV 4 1965		Robert E. Fisher, M.D.		Milton E. Ellickson 1129 N. Calhoun St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 11309</u>	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<u>MR. THEODORE E. SALTER</u>		<u>Nov. 2, 1965</u>		<u>8:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <u>Md.</u>		B. COUNTY <u>12-01</u>	
<u>416 BRETTON PLACE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<u>BALTIMORE</u>	
		D. STREET ADDRESS (If rural, give location)		<u>416 BRETTON PLACE</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	B. DATE OF BIRTH <u>9/24/1878</u>	9. AGE (In years last birthday) <u>87 YRS.</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MUSICIAN</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>WILLIAM H. SALTER</u>		14. MOTHER'S MAIDEN NAME <u>ALICE CORY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. B. HOLLY SMITH 416 BRETTON PLACE</u>	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular Disease</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>30 October 1965</u> to <u>2 November 1965</u> , that (1) (we) last saw the deceased alive on <u>30 Oct. 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Larry G. Tilley</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>2 Nov 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Larry G. Tilley</u>		23D. ADDRESS <u>1713 Taylor Ave, Baltimore Md 21234</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/4/65</u>		24C. NAME of CEMETERY or CREMATORY <u>DRUID RIDGE</u>	
24D. LOCATION (City, town, or county) (State) <u>PIKESVILLE, MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>H.W. MEARS &amp; SON 805 N. CALVERT ST.</u>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11310		CERTIFICATE OF DEATH		Registered No. 65 11310	
1. NAME OF DECEASED (Type or Print) <b>HENRY J. KELLER</b>						2. DATE AND HOUR OF DEATH <b>11/4/65</b> <b>7 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>11-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>39 W. Preston St.</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>May 10, 1908</b>		9. AGE (In years last birthday) <b>57</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clinton Keller</b>						14. MOTHER'S MAIDEN NAME <b>Georganna ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W II</b>				16. SOCIAL SECURITY NO. <b>224-10-9929</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy M Keller 39 W. Preston St.</b>			
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) DUE TO <b>Acute Coronary Occlusion</b> (B) DUE TO <b>Hypertensive Rteriosclerotic C.V. with Coronary Insufficiency.</b> (C) <b>Instant.</b> <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant.</b> <b>years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>April 20 1964</b> to <b>4 Nov 1965</b> , that (I) (we) last saw the deceased alive on <b>22 Oct 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Lauriston L. Keown</b> M.D., Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <b>4 Nov 65</b>			
23C. PHYSICIAN'S NAME (Type) <b>LAURISTON L. KEOWN</b>						23D. ADDRESS <b>M.D. 1382 INDEN AVE BALTIMORE MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/8/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc.</b>		25D. ADDRESS <b>1217 St. Paul St. 21202</b>			

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Hauptstadt  
mit Karabene

22. Okt. 1900

Antikarabene  
Hauptstadt

Antikarabene  
Hauptstadt



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11311		CERTIFICATE OF DEATH		Registered No. 65 11311	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>JOHN THOMPSON</b>		
2. DATE AND HOUR OF DEATH <b>11-2-65 7:30 AM.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MONTEBELLO STATE HOSPITAL</b>			A. STATE <b>MD.</b> B. COUNTY <b>13-02</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>2239 EUTAW PLACE</b>		
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11-24-24</b>	9. AGE (In years last birthday) <b>41</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>JOHN THOMPSON</b>		
14. MOTHER'S MAIDEN NAME <b>Edith WILLIAMS</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		
16. SOCIAL SECURITY NO. <b>096-18-6566</b>			17. INFORMANT ADDRESS <b>HOSPITAL RECORDS</b>		
18. <b>322.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) <b>ALTY NEUROPATHY</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 MOS.</b>		
ANTECEDENT CAUSES			(A) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <b>ALCOHOLISM</b>		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>LUNG ABSCESS</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>8-30 1965</b> to <b>11-2 1965</b> , that (1) (we) last saw the deceased alive on <b>11-2 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irving L. Cooperstein</b> M.D.			23B. DATE SIGNED <b>11-2-65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Irving L. Cooperstein</b>			23D. ADDRESS <b>MONTEBELLO STATE HOSPITAL, BALTO.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/8/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md</b>		24E. STATE (State) <b>MD</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Adolphus Halstead 1206 W North Ave</b>	

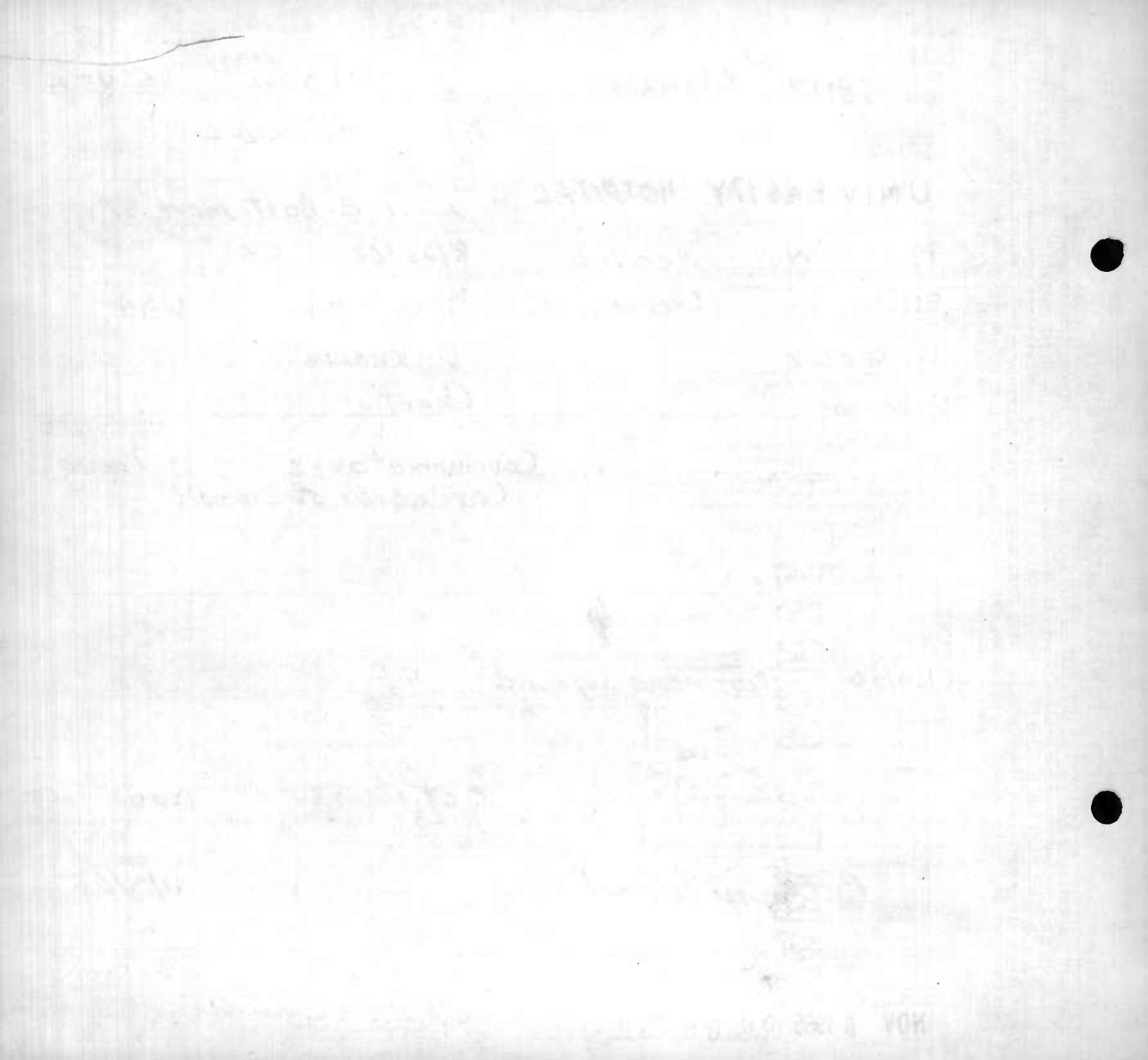




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 11313</span>	
BIRTH NO. <span style="float: right;">65 11313</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <span style="float: right;">PHILLIP</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">11/3/65 6:45 A.M.</span>	
(Type or Print) <span style="float: right;">Harry Kline</span>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <span style="float: right;">MD.</span> B. COUNTY <span style="float: right;">Baltimore</span>			
<b>UNIVERSITY HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		<b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location)			
		<b>2211 E. Baltimore ST.</b>			
5. SEX <span style="float: right;">M</span>	6. RACE <span style="float: right;">W</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="float: right;">Married</span>	8. DATE OF BIRTH <span style="float: right;">8/26/09</span>	9. AGE (In years last birthday) <span style="float: right;">56</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>Electrician</b>		<b>Chemical co.</b>		<b>Maryland</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<b>Unknown</b>		<b>Unknown</b>		<b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<b>Unknown</b>				<b>Chart</b>	
18. <span style="float: right;">153.3 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) DUE TO <span style="float: right;">Carcinomatosis</span>		<b>7 mo.</b>	
		<b>Carcinoma of Sigmoid</b>			
		(B) DUE TO			
		(C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="float: right;">11/28</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="float: right;">Carcinoma Sigmoid</span>		20A. AUTOPSY? (Yes or No) <span style="float: right;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">Oct. 1</span> 19 <span style="float: right;">65</span> to <span style="float: right;">Nov 3</span> 19 <span style="float: right;">65</span> , that (I) (we) lost saw the deceased alive on <span style="float: right;">Nov 2</span> 19 <span style="float: right;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">B. Ann Ward</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="float: right;">11/3/65</span>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">11/4/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Hebrew Young Men</span>	
				<b>Balto</b>	
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">NOV 5 1965</span>		25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Farley, M.D.</span>		25C. FUNERAL DIRECTOR <span style="float: right;">Sylvan S. Lewis &amp; Son, Inc.</span>	
				<b>3319 Olympic Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>64-34090</u> <u>65, 11312</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 11312</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Anthony Williams</u>		2. DATE AND HOUR OF DEATH <u>3 Nov. 1965</u> <u>1:45</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>18-02</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>422 Carrollton Ave</u> <u>DOA - Univ. Hosp</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>422 Carrollton Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>12-14-64</u>	9. AGE (In years last birthday) <u>10</u> <u>29</u> <u>+</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William William</u>		14. MOTHER'S MAIDEN NAME <u>Mary Carl</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT (man, in whose house) <u>Mr. McFadden (child was living)</u>		
18. <u>571.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Aspiration</u> DUE TO (B) <u>Gastroenteritis</u> DUE TO (C) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 d.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>-</u>					
19A. DATE OF OPERATION <u>0 No</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 30 1965</u> to <u>Nov 3 1965</u> , that (we) last saw the deceased alive on <u>Nov 2 1965</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Erlinda B. Corpuz</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>NOV. 3, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>ERLINDA B. CORPUZ</u>		23D. ADDRESS <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11/9/65</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>	
				ADDRESS <u>1206 W North Ave</u>	

GRINDA B. CORPUS

University Hospital

x

NOV 1955

BALTIMORE CITY HEALTH DEPARTMENT

65 11314 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11314

BIRTH NO. 65 11314

M.E. CASE NO. N-200

1. NAME OF DECEASED (Type or Print) <b>THOMAS NASH (Tom)</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>November 3, 1965 11:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1121 Laurens Street</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1121 Laurens St.</b>	
5. SEX <b>male</b>	6. RACE <b>negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 9, 1892</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>73</b>
13. FATHER'S NAME <b>James Nash</b>		14. MOTHER'S MAIDEN NAME <b>Alice Marshall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>218-05-5783</b>	17. INFORMANT ADDRESS <b>Hattie Evans 745 Richwood Ave.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>422.1 I Arteriosclerotic cardiovascular disease</b> DUE TO  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b> 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			INTERVAL BETWEEN ONSET AND DEATH
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11-3-65</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23B. DATE <b>11/8/65</b>	23C. NAME of CEMETERY or CREMATORY <b>Baltimore Natl. Cem</b>	23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Fink</b>	
24C. FUNERAL DIRECTOR <b>George A. Kline</b>		ADDRESS <b>1348 N. Calhoun St</b>	

VS 151-REV. 1/1/65





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11315		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11315	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		6A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		Md. 6-01	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
D. STREET ADDRESS (If rural, give location)		11 N. LINWOOD Ave.			
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH JAN. 11, 1883	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William T. Price		14. MOTHER'S MAIDEN NAME Louisa A. Schultz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. H. Schultz 11 N. Linwood Ave.	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardiac Decompensation DUE TO (B) Atherosclerotic Heart Dis. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 week 15 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles MacNimm M.D.				23B. DATE SIGNED Oct 29, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11-1-65		PARKWOOD CEMETERY BALTIMORE Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 5 1965		Robert E. Farley		B. Dabrowski 284 E. Balto. St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				65 11316	
BIRTH NO.				65 11316	
M.E. CASE NO.				65 11316	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Miller, Theresa (TERESA)			10/27/65 8:55 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
Baltimore			Md. 6-02		
5. SEX			6. RACE		
F			White		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
Widow			Sept 23, 1890		
9. AGE (In years last birthday)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
75			Housewife		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Baltimore			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Miller, William GOLDBECK			Nisson, Sophie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			Front Sheet		
17. INFORMANT			ADDRESS		
Front Sheet					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			(A) Intracerebral Hemorrhage		
ANTECEDENT CAUSES			(B) Hypertension		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
19C. DATE OF OPERATION			19D. TIME OF INJURY (APPROX.)		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. HOW DID INJURY OCCUR?		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
21G. WHILE AT WORK			21H. NOT WHILE AT WORK		
22. I certify that (I) (this hospital) attended the deceased from 10. 24. 1965 to 10. 27. 1965, that (I) (we) last saw the deceased alive on 10. 27. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Dr. Boomer			10.27.1965		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
M.D.			M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			10/30/65		
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Holy Redeemer Cem. Balto. Md.					
25A. DATE REC'D BY HEALTH/DEPT.			25B. NAME OF REGISTRAR		
NOV 5 1965			Robert E. Faldut		
25C. FUNERAL DIRECTOR			25D. ADDRESS		
B. Dabrowski			2818 E. Balto. St.		

US 153 - CHANGE NAME OF FATHER

III

FORBES

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

FLOYD BURKE

2. DATE AND HOUR PRONOUNCED DEAD

11/2/65 12:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1420 Millrace Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

2-8-1907

9. AGE (in years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

TIRE BUILDER

10B. KIND OF BUSINESS OR INDUSTRY

RUBBER CO.

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK

14. MOTHER'S MAIDEN NAME

UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

216-01-6165

17. INFORMANT

DESSIE M. BURKE

ADDRESS

1420 MILL RACE RD.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Multiple injuries

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

railroad tracks

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Railroad Ave. near Union Ave.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

11 2 65 12:05 a.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

run over by train

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/2/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-5-65

23C. NAME of CEMETERY or CREMATORY

MORELAND MEM PARK

23D. LOCATION

BALTO

(City, town, or county)

MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 5 1965

24B. NAME OF REGISTRAR

Paul E. Farber, M.D.

24C. FUNERAL DIRECTOR

Paul E. Chaveth, Jr.

ADDRESS

3615 Chestnut  
ave

WALLACE P. RICE

ADJUTANT

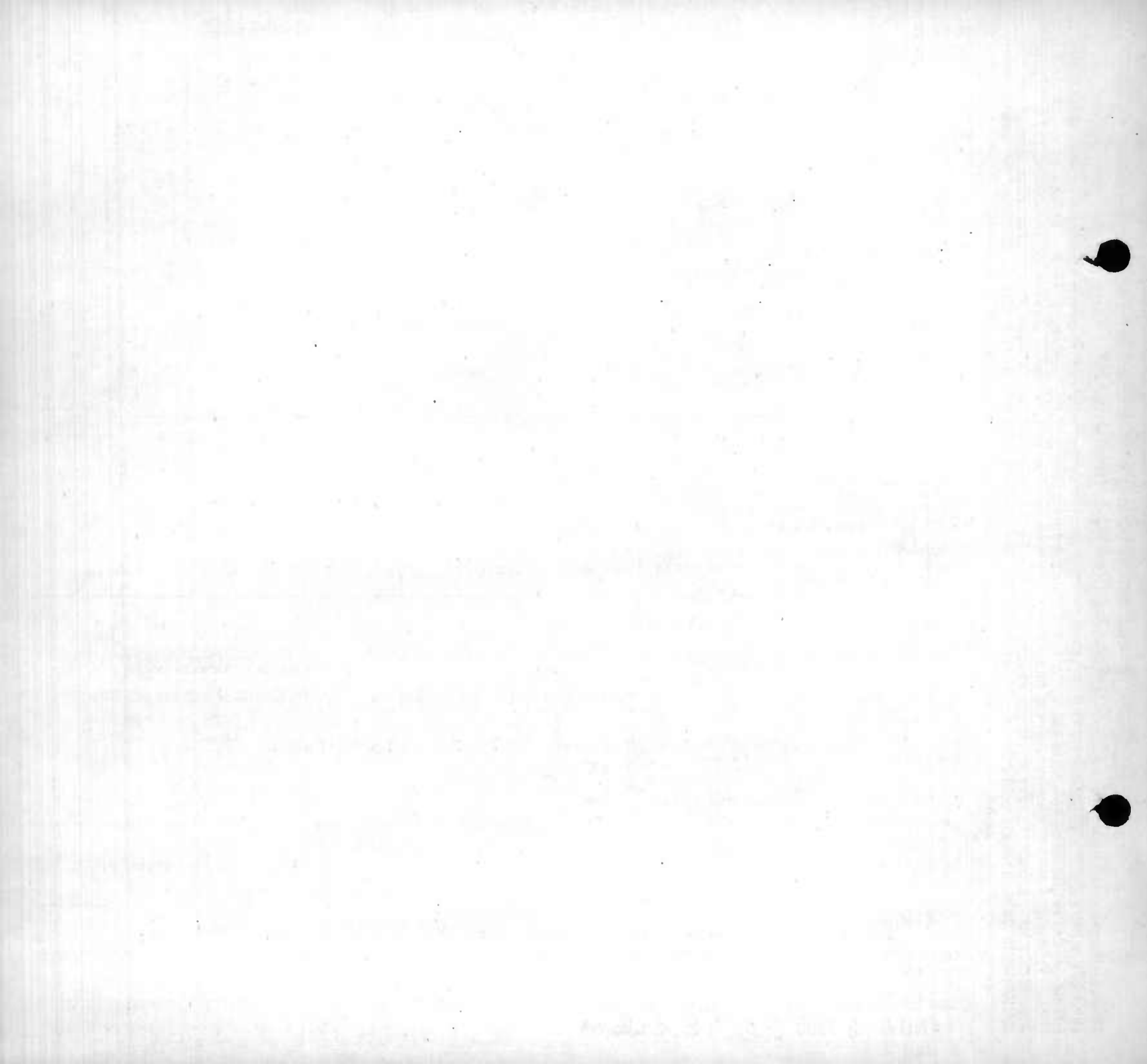
GENERAL



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65





new of Vital Records  
Municipal Bldg.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11319		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11319	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN BRETNALL POWELL		2. DATE AND HOUR OF DEATH OCT. 20 - 65 12:30 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 10 24 Indian Lane		A. STATE B. COUNTY 24 INDIAN LANE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-13			
		D. STREET ADDRESS (If rural, give location) MARYLAND			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/20/1901	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EASTERN SALES MGR.		10B. KIND OF BUSINESS OR INDUSTRY NAT. PLASTICS PROD. CO.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOHN ALLEN POWELL		14. MOTHER'S MAIDEN NAME CAROLINE LATHBURY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 221-03-2387		17. INFORMANT MARY MOSS POWELL	
				ADDRESS 24 INDIAN LANE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of Prostate DUE TO (B) with metastases DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 5 years					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to Oct 20 1965, that (I) (we) last saw the deceased alive on Oct 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Edward Stinson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Oct 20 1965	
23C. PHYSICIAN'S NAME (Type) EDWARD STINSON		23D. ADDRESS M.D. 18 E EAGER ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) WILLED TO		24B. DATE NOV 5 1965		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
		24D. LOCATION BALTIMORE MD.			
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1965		25B. NAME OF REGISTRAR Robert E. Farley, JR.		25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD FUNERAL HOME	
				ADDRESS 6500 YORK ROAD BALTO. 12, MD.	

Nov 1 1944

2nd Lt. James E. ...

1st Lt. ...

1st Lt. ...

1st Lt. ...

1st Lt. ...

1st Lt. ...

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1st Lt. ...

1st Lt. ...

1st Lt. ...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 11320</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 11320</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Claes, Lena</b>			2. DATE AND HOUR OF DEATH <b>November 3, 1965 11:00 A. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>FOL</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21224</b> D. STREET ADDRESS (If rural, give location) <b>3118 Elliott St.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March 2, 1895</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker (Formerly with Tindeco Co.)</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>214-03-6386</b>		17. INFORMANT <b>Frank Claes - 3118 Elliott St.</b>
18. <b>260X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Diabetic acidosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 1, 1965</b> to <b>November 3, 1965</b> , that (I) (we) last saw the deceased alive on <b>November 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Elmo M. Gayoso</b>				23B. DATE SIGNED <b>November 3, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Elmo M. Gayoso</b>				23D. ADDRESS <b>1400 N. Caroline St., Baltimore, Md. 21213</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/6/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	
24D. LOCATION <b>Balt Co. Ind.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>Geo. W. Hoffmann</b>			
25D. ADDRESS <b>3218 Hudson St.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11321</b>	
BIRTH NO. <b>65 11321</b>		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH <b>Nov. 2, 1965</b> <span style="float: right;"><b>1 P. M.</b></span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Emily L. Hewitt</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Gould Convalesarium - Baker Tr.</b> <b>6116 Baker Road.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>RURAL - Rosedale 5300</b> D. STREET ADDRESS (If rural, give location) <b>7523 Brightside Ave</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>Sept. 26, 1886</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houseless</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balt. City Hosp</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
13. FATHER'S NAME <b>Louis Dennis</b>		14. MOTHER'S MAIDEN NAME <b>Louise Collyer</b>		17. INFORMANT <b>Josephine Santoni</b> ADDRESS <b>7523 Brightside Ave.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-6090</b>			
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>CANCER OF BREAST</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2 AM, 3</b> <b>1951</b> to <b>Nov. 2</b> <b>1965</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 1, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benjamin Hylton</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>11/3/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. B. HILHSTEIN</b>		23D. ADDRESS M.D. <b>121 S. HIGHLAND AVE BALTO 24 MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-5-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Asbury Cemetery</b>	
24D. LOCATION <b>Perryville, Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Ralph E. Green</b> ADDRESS <b>1811 Chesaco Ave.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

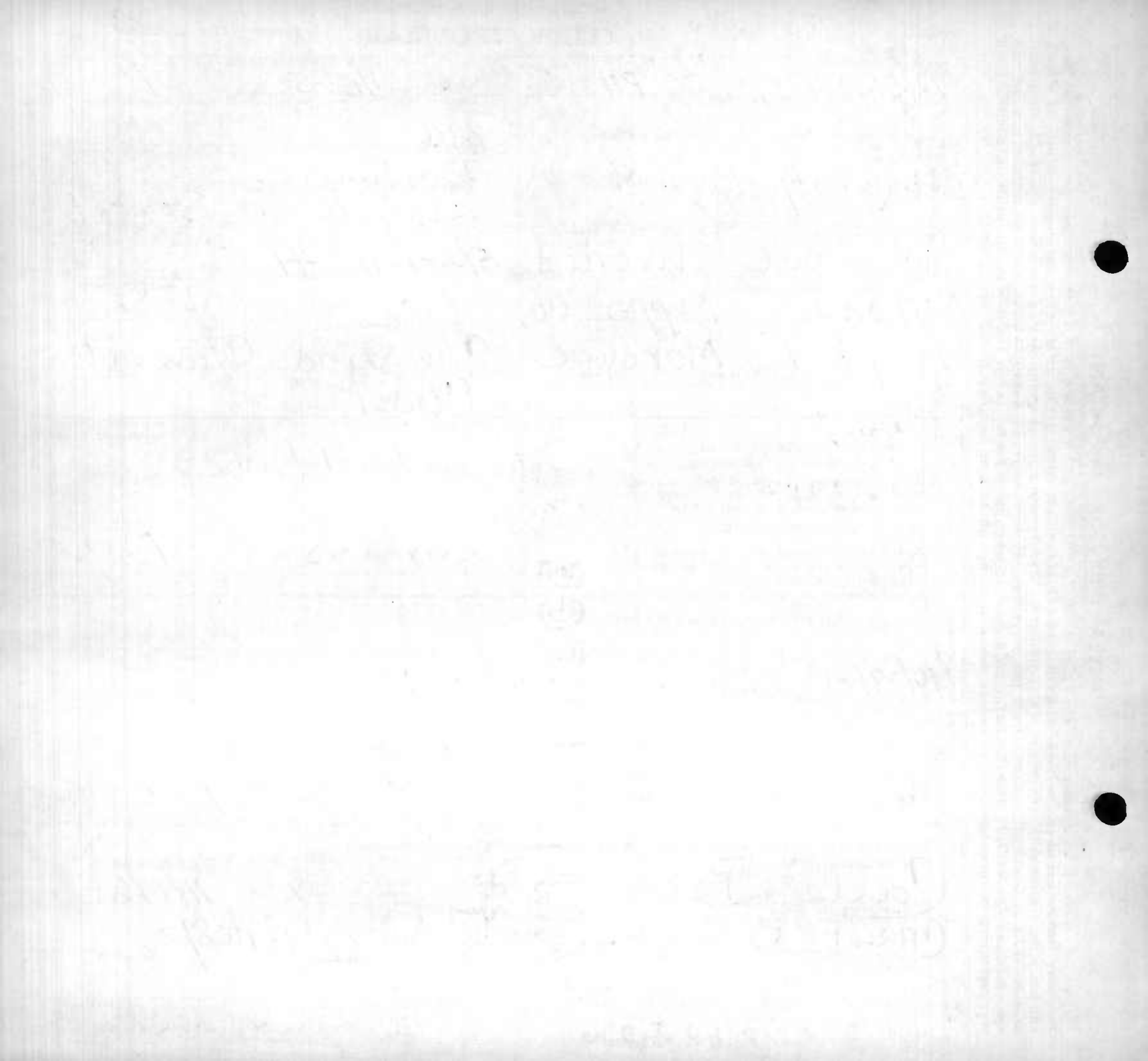
BIRTH NO. 65 11322				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11322	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ANASTASIA ZASIC</b>				2. DATE AND HOUR OF DEATH <b>Nov. 3, 1965</b> <b>9:15 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY <b>27-01</b>	
<b>2835 BRENDAN AVE.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>2835 BRENDAN AVE.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>April 10, 1865</b>	9. AGE (In years last birthday) <b>100</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Carhoun</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Sabatky</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Caroline K. Zelenka 2835 Brendan Ave</b>			
18. <b>331 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>cerebral arteriosclerosis</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Blindness</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1965</b> to <b>Nov. 3, 1965</b> , that (I) (we) lost saw the deceased alive on <b>Nov. 2, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>L. F. KLIMES</b> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/3/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>L. F. KLIMES M.D.</b>				23D. ADDRESS <b>2623 E. Monument St</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-6-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bohemian National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Philip J. Gach</b>		ADDRESS <b>1211 Chesaco Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11323		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11323	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MORAVEC, JOSEPH T. JR.		2. DATE AND HOUR OF DEATH 11/1/65 7:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.		B. COUNTY 8-01	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If wrong, give location) 2001 Rose Street	
5. SEX Male	6. RACE Cauc	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 5/26/24	9. AGE (In years last birthday) 41	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Koppers Co.		11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph T. Moravec		14. MOTHER'S MAIDEN NAME Christina Chovvat		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 219-14-0106		17. INFORMANT Chart		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 230X I		CAUSE OF DEATH (A) DUE TO Petroperitoneal tumor (B) DUE TO Post-necrotic cirrhosis (C)		INTERVAL BETWEEN ONSET AND DEATH 12 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10/29/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive jaundice		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/15/1965 to 11/1/1965, that (I) (we) last saw the deceased alive on 11/1/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Carl F. Berner		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/1/65	
23C. PHYSICIAN'S NAME (Type) CARL F. BERNER		23D. ADDRESS University Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-5-65	24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Philip J. Gould	
				ADDRESS 1211 Chesapeake	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 11324		BALTIMORE CITY HEALTH DEPARTMENT		65 11324	
BIRTH NO.		Registered No.			
M.E. CASE NO. Emma Sheppard					
1. NAME OF DECEASED (Type or Print) EMMA C. SHEPPARD			2. DATE AND HOUR OF DEATH Oct. 30, 1965 8 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 3-81		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) So. Balt. Gen. Hosp.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.		
D. STREET ADDRESS 282 S. SPRING COURT			E. DATE OF BIRTH SEP. 12, 1886		
5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			9. AGE (In years last birthday) 79		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) MARYLAND		
10B. KIND OF BUSINESS OR INDUSTRY NONE			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Samuel Talbert			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT MRS. E. KANE 27 N. Linwood Ave			ADDRESS		
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			(A) Cerebral Thrombosis		
ANTECEDENT CAUSES			(B) Hypertensive Cardiovascular Disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Cardiovascular Disease		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Dehydration		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10-24-65 to 10-30-65, that (we) last saw the deceased alive on 10-30-65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Calvin E. Jones Jr. M.D.			23B. DATE SIGNED 12/21/65		
23C. PHYSICIAN'S NAME (Type) Calvin E. Jones Jr.			23D. ADDRESS South Balt. General Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-4-65		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	
24D. LOCATION Baltimore Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1965		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR Bernard Labrowski Jr.	
25D. ADDRESS 2515 E. BALTIMORE ST.					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11325				BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH				Registered No. 65 11325			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) STEWART LARRABEE				2. DATE AND HOUR OF DEATH Nov. 4, 1965 2 <sup>00</sup> A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home				A. STATE Maryland				B. COUNTY 27-14			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City							
				D. STREET ADDRESS (If rural, give location) 7 Beechdale Road, Roland Park							
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH Aug. 8, 1874		9. AGE (In years last birthday) 91 yrs.		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman				10B. KIND OF BUSINESS OR INDUSTRY Dry Goods		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel Larrabee				14. MOTHER'S MAIDEN NAME Janet Claybaugh							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 216-10-7897		17. INFORMANT: Atty. Hinkley & Singley 1600 1st. Natl Bak Bldg.				ADDRESS City	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 450.0 I Arteriosclerosis				CAUSE OF DEATH (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO							
(C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1958 to Nov 4 1965, that (I) (we) last saw the deceased alive on Nov 3rd 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.											
23A. SIGNATURE William G. Helfrich				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov 4 1965					
23C. PHYSICIAN'S NAME (Type) William G. Helfrich, M.D.				23D. ADDRESS 5006 Roland Ave. Balto 14, MD							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1965				25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co., 108 W. North Av. City					



Attestation

1908  
23 26 28

Attestation

Attestation

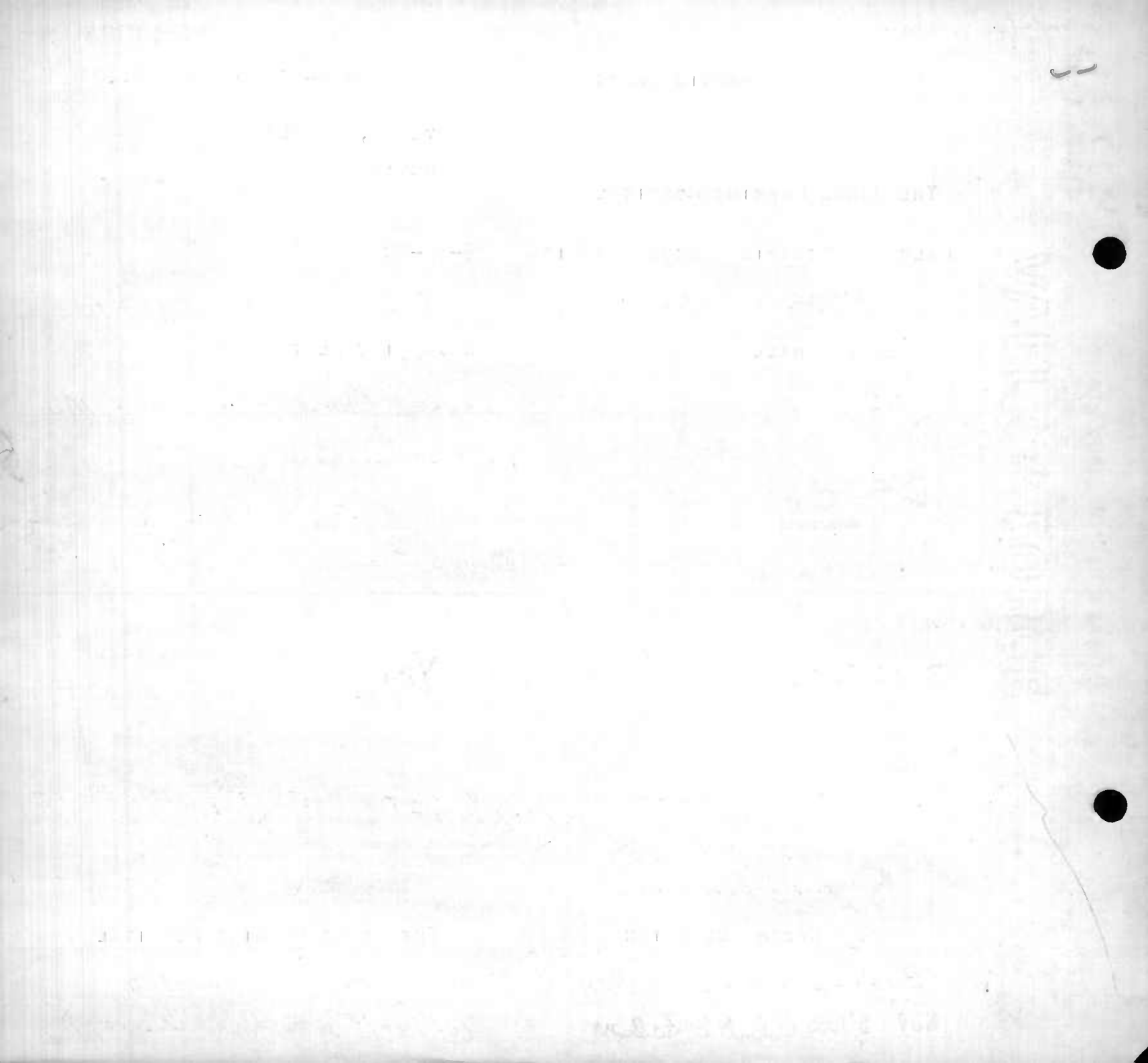




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>D.C.</i> 65 11327		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11327	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANCIS CHASE		2. DATE AND HOUR OF DEATH 10-30-65 3:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, CHARLES B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) HUGHESVILLE 58-00 D. STREET ADDRESS (If rural, give location)			
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9-23-59	9. AGE (in years last birthday) 6	(If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE CHASE		14. MOTHER'S MAIDEN NAME CATHERINE PLATER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT GEORGE CHASE, HUGHESVILLE, MD.	
18. 237X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Cardiorespiratory arrest (B) DUE TO Cerebral softening and edema (C) DUE TO Brain tumor		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 3/10/25/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor		20A. AUTO-PSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 9/1/24 1965 to 3:20 p.m. 10/30/1965, that (I) (we) last saw the deceased alive on 10/30/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kazem Ambassian		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/30/65	
23C. PHYSICIAN'S NAME (Type) KAZEM AMBASSIAN		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-4-65		24C. NAME OF CEMETERY or CREMATORY ST. MARY'S Cem.	
24D. LOCATION (City, town, or county) (State) BRYANTOWN, MD.		25A. DATE REC'D BY HEALTH DEPT. NOV 5 1965			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR THE HUNT FUNERAL HOME, WALDORF, MD.			



BIRTH NO.

65 11328

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 11328

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MELVIN

BENGES

2. DATE AND HOUR PRONOUNCED DEAD

November 3, 1965

11:30 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1148 Ward Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10/16/1941

9. AGE (In years  
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.  
Months; Days; Hours; Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Benges

14. MOTHER'S MAIDEN NAME

Blanche Bantz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

✓

17. INFORMANT

Mrs Florence Jones

ADDRESS

2007 Casadel Ave  
30, Md.

18.

E 874.9

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Narcotic Intoxication.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

✓

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Unknown

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

00-00

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11 3 '65

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Overdose of a narcotic.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
11/4/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/6/65

23C. NAME of CEMETERY or CREMATORY

Glen Haven Cem.

23D. LOCATION

Ritchie Hwy

(City, town, or county)

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 5 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

John J. Cowan, Sr. Inc.

ADDRESS

901 St.  
Hollins

28, Md. ✓

MAILLEY PORCEL

PROPORTION

U.S.A.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11329				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11329	
1. NAME OF DECEASED (Type or Print) <b>MACKS, ROSE</b>				2. DATE AND HOUR OF DEATH <b>Nov. 1, 1965 110 p M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-11</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3506 LIBERTY HEIGHTS AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9/20/1892</b>		9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DR. HARRIS FLINDER</b>				14. MOTHER'S MAIDEN NAME <b>LENA GEBHART</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT ADDRESS <b>DR. ISAAC M. MACKS 3506 LIBERTY HEIGHTS AVE</b>			
18. <b>420.14-260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetic Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>10/31</b> 19 <b>65</b> to <b>11/1</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>11/1</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. S. [Signature]</b>				23B. DATE SIGNED <b>11/1/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>M. S. [Signature]</b>				23D. ADDRESS M.D. <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/2/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>		25B. NAME OF REGISTRAR <b>R. E. [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>			

WILLIAM H. HARRIS  
JAMES H. HARRIS  
JAMES H. HARRIS

JAMES H. HARRIS

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JAMES H. HARRIS

*W. H. Harris*

W. H. Harris

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11330		CERTIFICATE OF DEATH		Registered No. 65 11330	
1. NAME OF DECEASED (Type or Print) <b>AARON MILLER</b>				2. DATE AND HOUR OF DEATH <b>NOVEMBER 3, 1965 2: 25 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>11-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1302 ST. PAUL STREET</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED <b>DIVORCED</b> (specify)	8. DATE OF BIRTH <b>1/31/1901</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EMPLOYEE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CHESAPEAKE RESTAURANT</b>		11. BIRTHPLACE (State or foreign country) <b>DURHAM, N. CAROLINA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>SIMON MILLER</b>				14. MOTHER'S MAIDEN NAME <b>SARAH CAPLAN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-8500</b>		17. INFORMANT <b>MRS. MINNIE KATZ</b>			ADDRESS <b>2910 LIGHTFOOT DRIVE</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Acute Coronary Occlusion</b> DUE TO (B) <b>Arteriosclerotic Heart Dis.</b> DUE TO (C) <b>Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 min</b> <b>12 yrs</b> <b>20 yrs</b>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 23 1958</b> to <b>Oct 18 1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Oct 18 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Jonas Cohen</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Nov. 3, 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. JONAS COHEN</b>		23D. ADDRESS <b>6702 PARK HEIGHTS AVENUE</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/4/65</b>		24C. NAME of CEMETERY or CREMATORY <b>HEBREW FRIENDSHIP</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>					

AMERICAN AIRLINES

W. H. P. H.

RECEIVED

1200 ST. JOHN STREET

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THE AMERICAN AIRLINES

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11331		CERTIFICATE OF DEATH		Registered No. 65 11331	
1. NAME OF DECEASED (Type or Print) <b>CAROLYN ABESHOUSE</b>				2. DATE AND HOUR OF DEATH <b>NOVEMBER 3, 1965</b> <b>9 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>100 WEST MONUMENT STREET</b>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>100 WEST MONUMENT STREET</b>					
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>8/12/1903</b>		9. AGE (In years lost birthday) <b>62</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LOUIS KEHRMAN</b>				14. MOTHER'S MAIDEN NAME <b>MINNIE ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>DR. GEORGE A. ABESHOUSE 2504 SHELLYDALE RD</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MI</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Coronary Insufficiency</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1957</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>4/7</b> 19 <b>57</b> to <b>11/3</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>11/2</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Dr. Israel Zinberg</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>11/3/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. ISRAEL ZINBERG</b>				23D. ADDRESS <b>4000 W. NORTHERN PARKWAY</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/5/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11332		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11332	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) OLIVE MITCHELL	
2. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. DATE AND HOUR OF DEATH 3 NOVEMBER 1965 11:59 PM	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSP. BALTIMORE MD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY H. Harford		C. CITY OR TOWN (If outside city limits, write RURAL and give township) LAUREL	
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 11/14/18		9. AGE (In years lost birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DESOUIN	
14. MOTHER'S MAIDEN NAME ROSE KOLAMUS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOWARD MITCHELL HUSBAND. 704 GORMAN AVE APT 101		18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
(A) DUE TO ACUTE CORONARY OCCLUSION DAYS		(B) CORONARY ARTERIO SCLEROSIS YEARS		(C) CEREBRAL THROMBOSIS DAYS	
19. DATE OF OPERATION 0		20. AUTOPSY? (Yes or No) NO		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from 3 NOVEMBER 19 65 to 3 NOVEMBER 65, that (I) (we) last saw the deceased alive on 3 NOVEMBER 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE RICHARD D. BIGGS JR. M.D. Attending Phys. Med. Director Staff Phys. 3 NOVEMBER 65		24. DATE SIGNED 3 NOVEMBER 65	
25. A. BURIAL CREMATION, REMOVAL (Specify) Burial		26. DATE 11/6/65		27. NAME OF CEMETERY OR CREMATORY Ivy Hill	
28. LOCATION (City, town, or county) Laurel Md		29. DATE REC'D BY HEALTH DEPT. NOV 5 1965		30. NAME OF REGISTRAR Robert E. Fisher M.D.	
31. FUNERAL DIRECTOR W.R. Selly		32. ADDRESS 502 4th St Laurel Md		33. DATE REC'D BY HEALTH DEPT. NOV 5 1965	





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>65 11333</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 11333</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES R. COKER</b>		2. DATE AND HOUR OF DEATH <b>3 NOVEMBER 65 5<sup>25</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSP BALTIMORE MD</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 2302</b>			D. STREET ADDRESS (If rural, give location) <b>1522 PATAPSCO ST</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8/9/99</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>1st PR. Forman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>W.M. P. P. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>LENOIR Co., NORTH CAROLINA</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN COKER</b>			14. MOTHER'S MAIDEN NAME <b>BETTY BROWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>705-10-6417</b>		17. INFORMANT <b>Mrs. Marie O. Coker</b> ADDRESS (same) <b>WIFE, SELF</b>	
18. <b>332X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>① MIDDLE CEREBRAL ARTERY THROMBOSIS</b> DUE TO (B) _____ DUE TO (C) _____		
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1 NOV. 19 65</b> to <b>3 NOV. 19 65</b> , that (I) (we) last saw the deceased alive on <b>3 NOV. 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard D. Biggs Jr.</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3 Nov. 65</b>
23C. PHYSICIAN'S NAME (Type) <b>RICHARD D. Biggs JR</b>			23D. ADDRESS <b>UNIVERSITY HOSP BALTO. MD</b>		
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Sat. Nov 6 1965</b>	24C. NAME OF CEMETERY or CREMATORY <b>Green Haven Cem., Glen Burnie, Md.</b>		24D. LOCATION (City, town, or county) (State) <b>CURTIS E. EVANS</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Falker, JR</b>		25C. FUNERAL DIRECTOR <b>14005 CHARLES ST. BALTO. MD 21230</b>	

CURTIS E. EVANS

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11334		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11334	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Henry Sampson, Jr.		2. DATE AND HOUR OF DEATH Nov. 1, 1965 1:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1124 Etting Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 17-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 1124 Etting Street			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 20, 1888	9. AGE (In years lost birthday) 77	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Henry Sampson		14. MOTHER'S MAIDEN NAME Mary?		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Nellie Sampson 1124 Etting Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) I 15-1X Carcinoma of the stomach with metastasis to lungs and liver		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 16, 1965 to Nov. 1, 1965, that (I) (we) lost saw the deceased alive on Oct. 28, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard Harris Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov 3, 1965	
23C. PHYSICIAN'S NAME (Type) Bernard Harris Jr.		23D. ADDRESS 1200 McCallum St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/65		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 5 1965		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR Joseph P. Phas		25D. ADDRESS 2222 St. North Ave		25E. 21216	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11335</b>	
BIRTH NO. <b>65 11335</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Ida Churchill</b>			2. DATE AND HOUR OF DEATH <b>October 31, 1965</b>   <b>10:30 A. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>14-02</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>505 Laurens Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Col</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>May 10, 1901</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Robert Talson</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Ernest Churchill 505 Laurens Street</b>		
18. <b>332X1+260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cerebral Thrombosis</b> DUE TO (B) <b>Generalized Atherosclerosis</b> DUE TO (C) <b>Essential Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>   <b>6 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>		<b>14 years</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>August 1963</b> to <b>October 31, 1965</b> , that (I) <del>was</del> last saw the deceased alive on <b>October 31, 1965</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>We</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>Charles R. Venter</b> M.D.				23B. DATE SIGNED <b>November 1, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES R. VENTER</b> M.D.				23D. ADDRESS <b>2320 Eutaw Place Ball's 2017</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov. 4, 65</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Arlington S. Phillips 1727 N. Monroe St.</b>			





BIRTH NO. 65 11336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11336

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SARAH HALL TILLMAN

2. DATE AND HOUR PRONOUNCED DEAD

November 2, 1965 3:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

704 N. Appelton St.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

6-9-1921

9. AGE (In years  
lost birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

25-22-6201

17. INFORMANT

ADDRESS

Walter Tillman 704 N. Appelton St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchopneumonia  
DUE TO epilepsy and cerebral infarct

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty metamorphosis of the liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/3/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/6/65

23C. NAME of CEMETERY or CREMATORY

Mt. Airy

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

NOV 5 1965

24B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Marshall P. Hays 638 N. Gilman St

WALLIE FORD

PRO CONTACT

DEAR

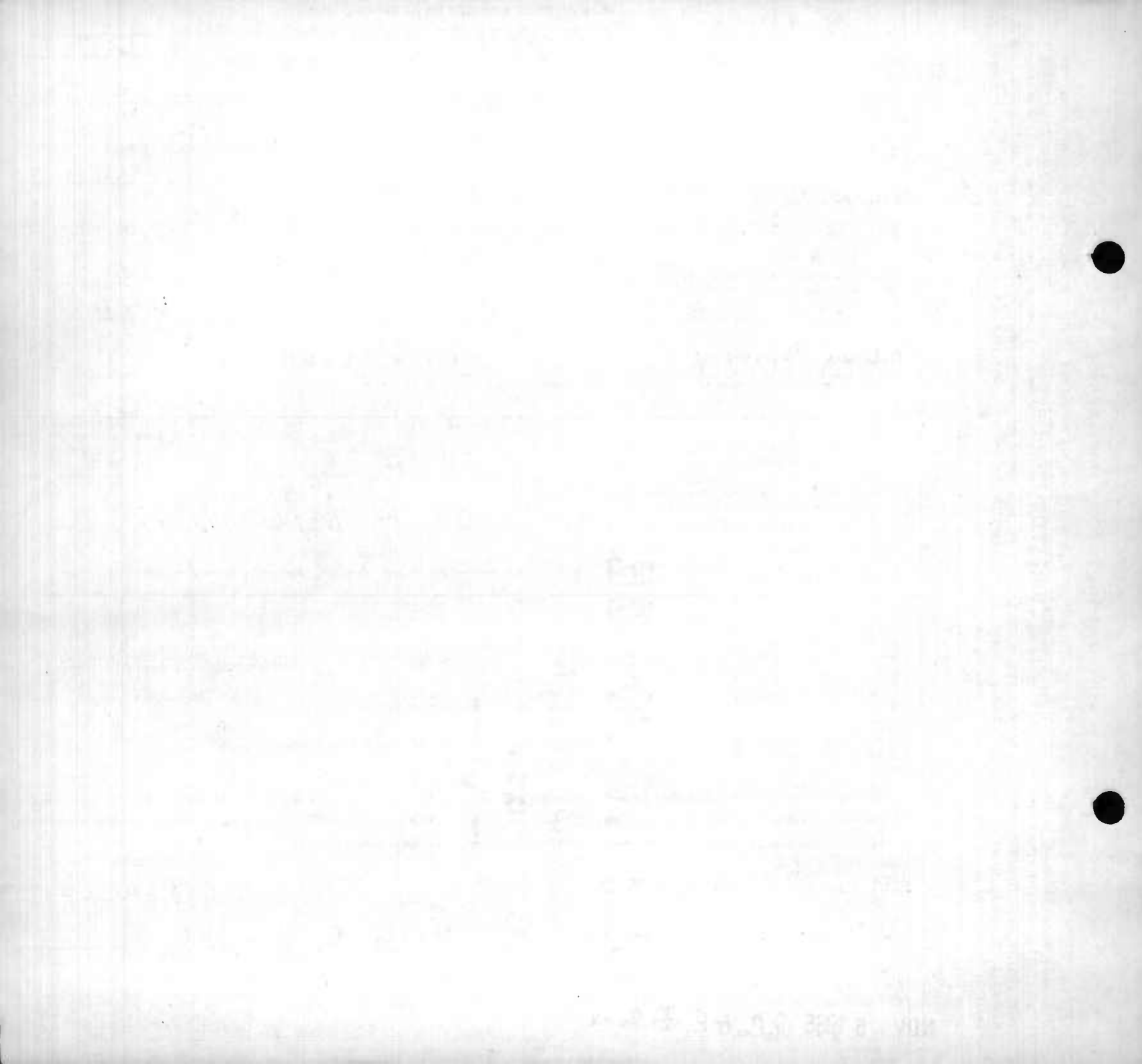
1-2-1

*Handwritten signature*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 11337</span>	
<div style="display: flex; justify-content: space-between;"> <div> <p><b>BIRTH NO.</b> <span style="font-size: 1.2em;">65 11337</span></p> <p><b>M.E. CASE NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.1em;">Alice Griffin</span></p> </div> <div> <p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.1em;">1 Nov. 65 10 45 A.M.</span></p> </div> </div>					
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.1em;">University</span></p>			<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <span style="font-size: 1.1em;">Md.</span> B. COUNTY <span style="font-size: 1.1em;">Baltimore City</span></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.1em;">Baltimore</span></p> <p>D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.1em;">1622 Edmondson Ave</span></p>		
<b>5. SEX</b> <span style="font-size: 1.1em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.1em;">N</span>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <span style="font-size: 1.1em;">married</span>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.1em;">5-19-13</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.1em;">52</span>	<b>10. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.1em;">U.S.A.</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">HOMEMAKER</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.1em;">At Home</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.1em;">Plymouth - N.C.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.1em;">Asbury Spivey</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.1em;">Alice Leathers</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or doles service) <span style="font-size: 1.1em;">no</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.1em;">None</span>		<b>17. INFORMANT</b> <span style="font-size: 1.1em;">James Griffin 1622 Edmondson Ave</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.1em;">UREMIA</span>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.1em;">DIABETIC Nephropathy</span>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.1em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">Oct. 26</span> 19 <span style="font-size: 1.1em;">65</span> to <span style="font-size: 1.1em;">Nov. 1</span> 19 <span style="font-size: 1.1em;">65</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">Nov. 1</span> 19 <span style="font-size: 1.1em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.1em;">Richard P. Norgaard</span> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.1em;">1 Nov. 65</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.1em;">Richard P. NORGARD</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.1em;">University Hospital</span>			
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.1em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.1em;">11/6/65</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.1em;">West Calvary</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore 21225</span>					
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.1em;">NOV 5 1965</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.1em;">Robert E. Farley M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.1em;">Marshall P. Hays 638 N. Gilmore St</span>	



65 11338

BALTIMORE CITY HEALTH DEPARTMENT

65 11338

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BLANCHE

GILES

2. DATE AND HOUR PRONOUNCED DEAD

11/1/65 8:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1824 W. Lexington St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

NOV 2-1911

9. AGE (In years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

CHESTER S.C

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

THOMAS GILES

14. MOTHER'S MAIDEN NAME

SISSELEY HEATHERTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Jesse Giles 1824 W Lexington

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic and hypertensive cardio-  
vascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Werner U. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/2/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/6/1965

23C. NAME of CEMETERY or CREMATORY

Arlington Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Arlington Baltimore 21227

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 5 1965

Robert E. Fadden

Thomas J. Hargis 638 W. Cameron St

WALLLEY FORT

NO. 100

USA

1



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 11339		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11339	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mr. HEDGEPEETH, William Herbert				2. DATE AND HOUR OF DEATH 1965, 11. 3 6.35A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE M.D. B. COUNTY 27-34 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4000 Hamilton Ave, #			
5. SEX male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1990.2.6.	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A Chauffeur		11. BIRTHPLACE (State or foreign country) North Carolina
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A Chauffeur			10B. KIND OF BUSINESS OR INDUSTRY Davidson Transfer		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME William Hedgepeth. (dead)				14. MOTHER'S MAIDEN NAME Martha (dead)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-09-5659		17. INFORMANT Lillian M. Hedgepeth-4000 Hamilton Av.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) possible stroke, DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. generalized arteriosclerotic vascular disease & CVA. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) (No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/22 1965 to Nov 3 1965, that (I) (we) lost saw the deceased alive on 6.35AM Nov 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Pyung Il Kwon M.D.				23B. DATE SIGNED Nov 3, 1965			
23C. PHYSICIAN'S NAME (Type) PYOUNG IL KWON				23D. ADDRESS The Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/65		24C. NAME of CEMETERY or CREMATORY Meadowridge Mem. Park		24D. LOCATION (City, town, or county) (State) Howard Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1965		25B. NAME OF REGISTRAR Robert E. Fadden, M.D.		25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc.		25D. ADDRESS 6009 Harford Rd.	



AT COM A CONE BOARD

CHINESE

BALTIMORE CITY HEALTH DEPARTMENT

65 11340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11340

BIRTH NO. 65 11340

M.E. CASE NO.

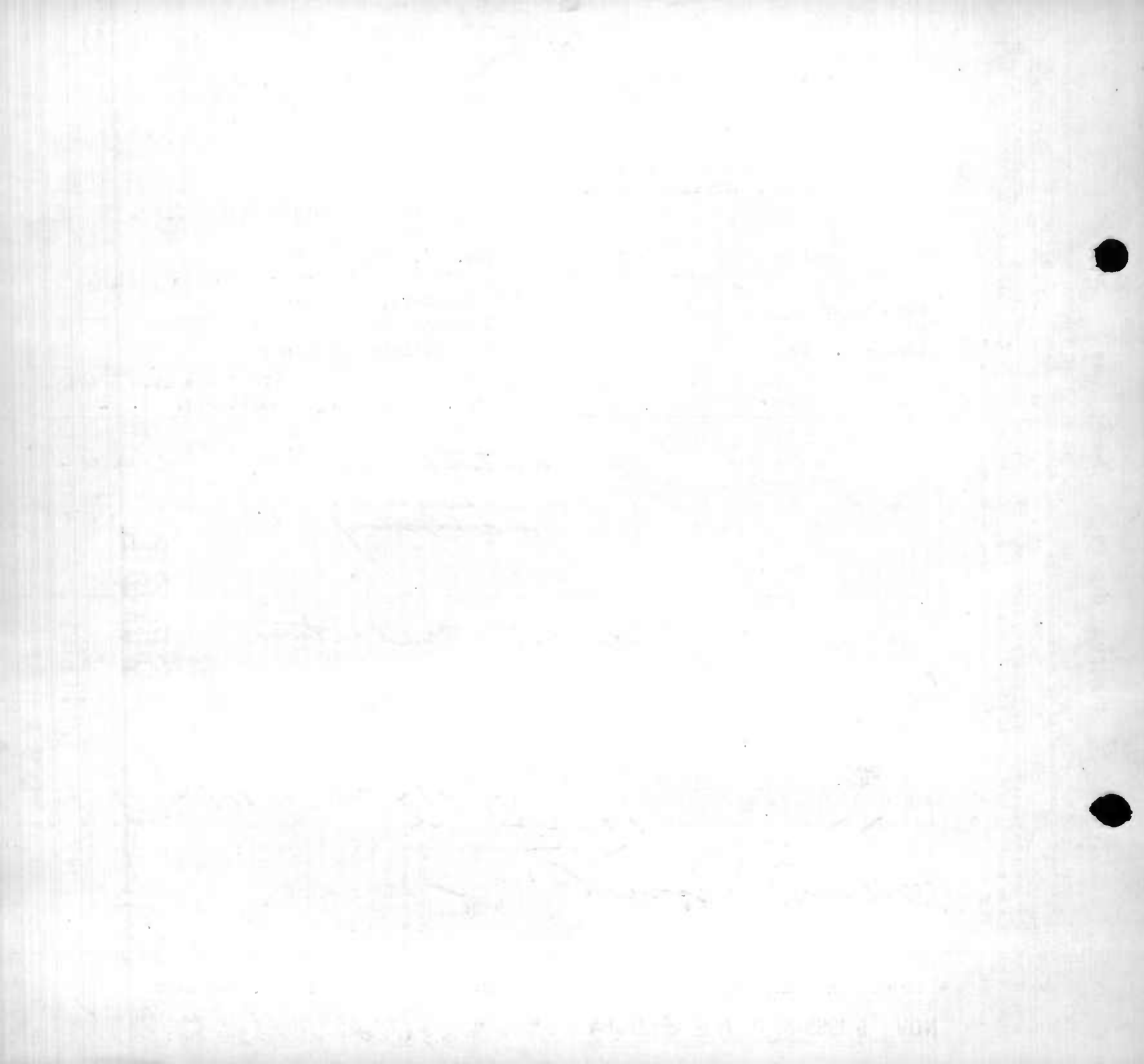
1. NAME OF DECEASED (Type or Print) LUCILLE JACKSON		2. DATE AND HOUR PRONOUNCED DEAD November 4, 1965 7:50 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home and Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1604 E. Lombard Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH April 18, 1927
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 38
13. FATHER'S NAME Lewis Phillips		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Essie Jackson	
17. INFORMANT Essie Camper		ADDRESS Cambridge, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sickle Cell Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 11/4/65			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 11/8/65	23C. NAME OF CEMETERY or CREMATORY Lincoln Road	23D. LOCATION (City, town, or county) (State) Dorchester Co., Md.
24A. DATE REC'D BY HEALTH DEPT. NOV 5 1965	24B. NAME OF REGISTRAR Robert E. Farley, M.D.	24C. FUNERAL DIRECTOR Frederick C. Deane	ADDRESS Cambridge, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.				65 11341		65 11341	
1. NAME OF DECEASED (Type or Print)				Horace Robert Young		2. DATE AND HOUR OF DEATH November 4, 1965 17 45 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 920 Pennsylvania Avenue Baltimore, Maryland 21201				A. STATE Maryland B. COUNTY 17-01 C. CITY OR TOWN Baltimore D. STREET ADDRESS 920 Pennsylvania Avenue 21201			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 25, 1919	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pawn Broker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Yonkers, New York		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Horace G. Young				14. MOTHER'S MAIDEN NAME Katinka Werner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Jewel Young ADDRESS 920 Pennsylvania Ave Baltimore, Md. 1			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 161X260X DUE TO metastatic ca carcinoma of lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 mos 3 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/7/52 to 11/4/65, that (I) (we) last saw the deceased alive on 10/22/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE William J. Fisher				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11/4/1965		24C. NAME of CEMETERY or CREMATORY Greenmount Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Wm. J. Fisher & Sons		ADDRESS Baltimore, Md. 17	



BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BERTHA HARRIS

2. DATE AND HOUR PRONOUNCED DEAD

Nov. 2, 1965

1:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital 1/4/66

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2233 Madison Ave.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

Jan. 21, 1937

9. AGE (In years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Colly

14. MOTHER'S MAIDEN NAME

Bertha Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Family

ADDRESS

419 Mosher St.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

" Acute pancreatitis "

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Nov. 7, 1965

23C. NAME of CEMETERY or CREMATORY

Abraham Mealey Cem.

23D. LOCATION

Goochland

(City, town, or county)

Va.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 5 1965

24B. NAME OF REGISTRAR

Robert E. Farkner

24C. FUNERAL DIRECTOR

Sullivan Funeral Home - N. Arlington Ave

ADDRESS

Letter from Medical examiner.

WALLACE V. BOND

W. B. Bond

W. B. Bond

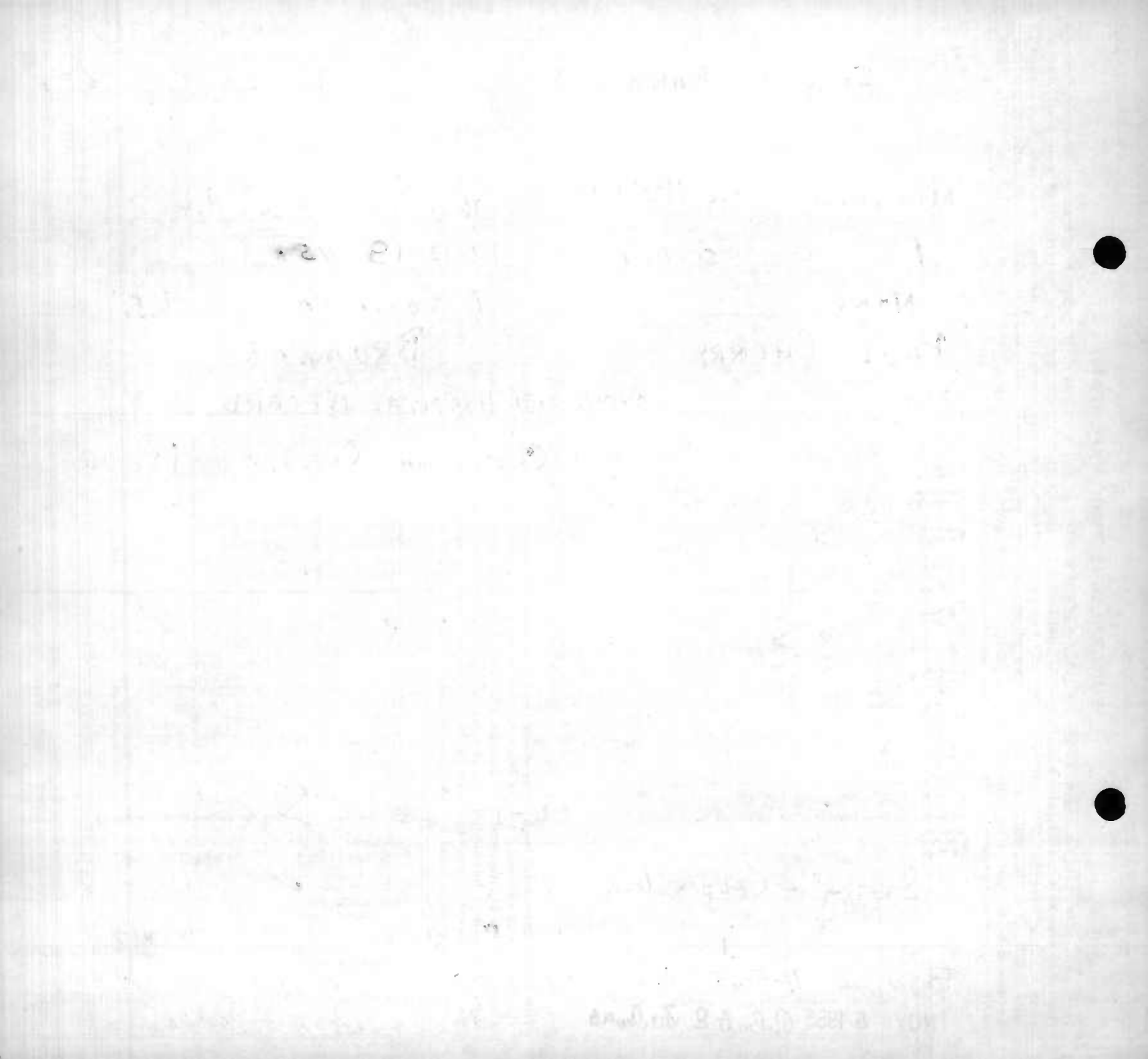
W. B. Bond



# FUNERAL DIRECTOR: IMPORTANT

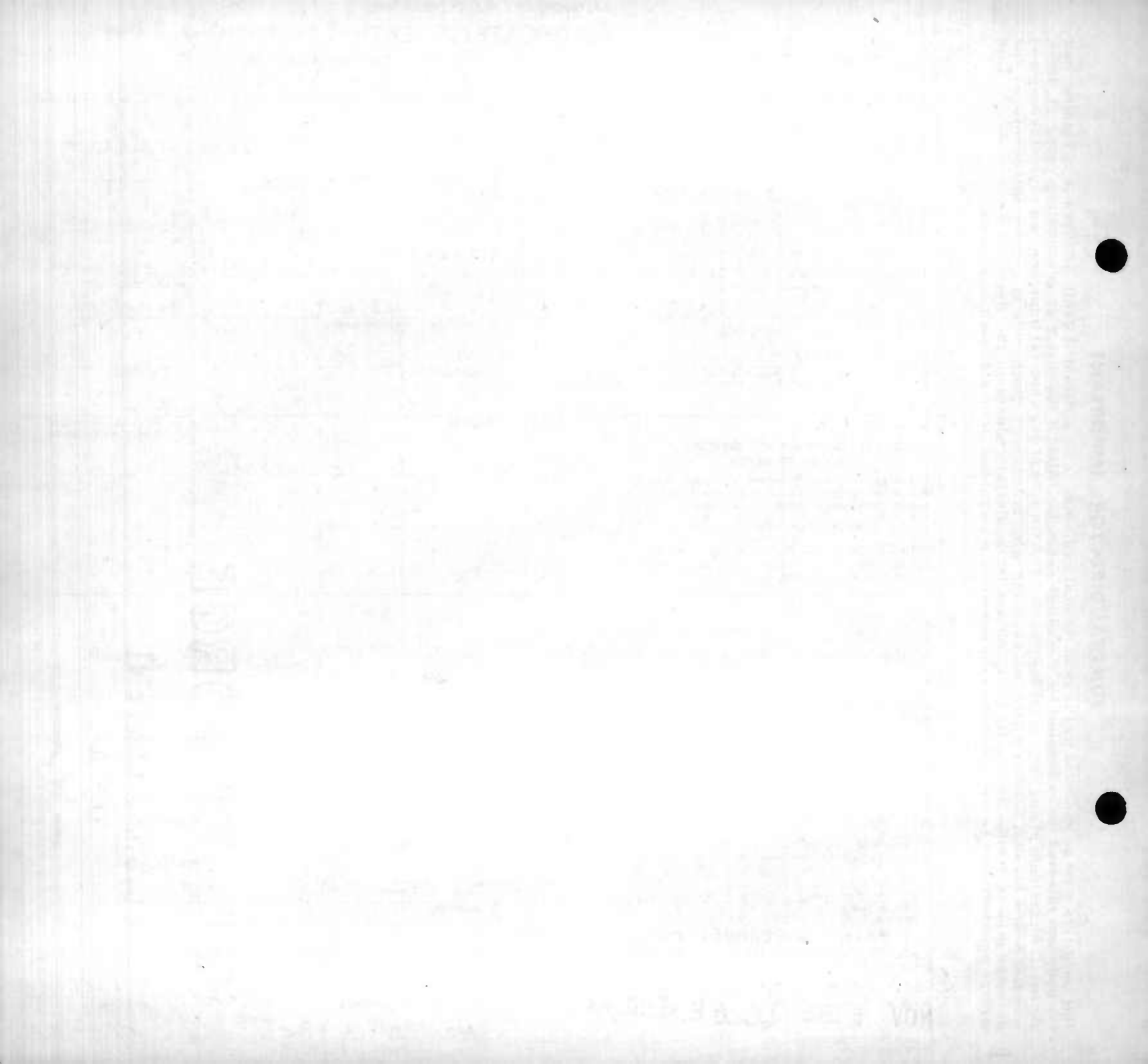
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11343				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11343	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) SELENA FARBEE (Farabee)						11-1-65 6:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
MONTEBELLO STATE HOSPITAL				MD.		14-02	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTO.			
				D. STREET ADDRESS (If rural, give location)			
				1618 DRUID HILL AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
F	C	SEPARATED	12-12-19	45			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
NONE					N. CAROLINA		U.S.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
PAUL CHERRY				BRUNNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
No			240-16-2181		HOSPITAL RECORD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) CARCINOMA CERVIX		1 YEAR	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 5-10 19 65 to 11-1 19 65, that (1) (we) last saw the deceased alive on 11-1 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Irving L. Cooperstein				11-1-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Irving L. Cooperstein				M.D. MONTEBELLO STATE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL	11-5-65	MT. Auburn		BALTO MD.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 5 1965		Robert E. Farber, M.D.		Morton Pyett		1701 LAWRENS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



65 11345

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11345

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES

THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

November 3, 1965

10:32 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

408 N. Calhoun Street

5. SEX

Male

6. RACE

Negro

7. MARRIED; NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Unknown

8. DATE OF BIRTH

June 1, 1935

9. AGE (in years  
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George Dukes

14. MOTHER'S MAIDEN NAME

Etta Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)

Yes

World War II

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Rooks

ADDRESS

18.

420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Coronary Artery Thrombosis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Arteriosclerotic Heart Disease.  
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
(If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/4/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Rocky Mount N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 5 1965

Robert E. Farley, M.D.

Melba E. Edickson 1129 N. Calhoun St

VALLEY FORCE

PROCESSION

1921

NOV 1 1921

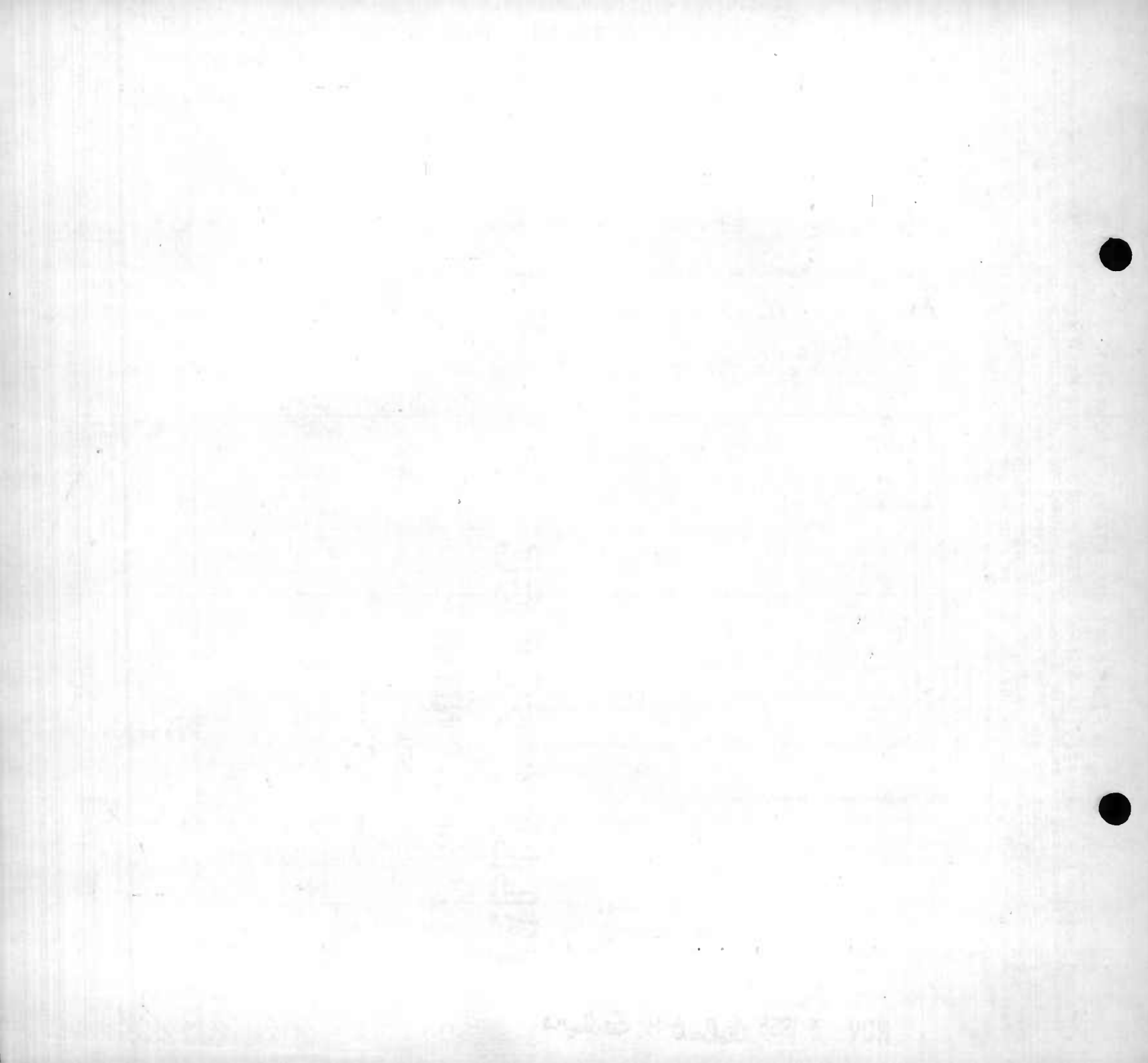


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11346		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11346	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) FANNIE SPEARMAN		
2. DATE AND HOUR OF DEATH 11-3-65 12:51PM M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1244 NORTH BROADWAY BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 8-07		
5. SEX F 6. RACE C 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEP			8. DATE OF BIRTH 3-6-00 9. AGE (In years last birthday) 65		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Fayetteville N.C.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME EVANDER MC MILLAN			14. MOTHER'S MAIDEN NAME EMMA MC NAIR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-242166		
17. INFORMANT			ADDRESS		
18. 175.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) Hepatic failure DUE TO (B) Ovarian carcinoma, probably ovary 6 months DUE TO (C)		
19. 175.0 I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/24/65 19 to 11/65 19, that (I) (we) lost saw the deceased alive on 10/28/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip J Burke M.D.				23B. DATE SIGNED 11-4-65	
23C. PHYSICIAN'S NAME (Type) PHILIP BURKE, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/65		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cem.	
24D. LOCATION Annet, Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 5 1965		24F. NAME OF REGISTRAR Robert E. Farber	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. DATE	
24J. NAME OF REGISTRAR		24K. FUNERAL DIRECTOR		24L. ADDRESS	
24M. DATE		24N. NAME OF REGISTRAR		24O. FUNERAL DIRECTOR	
24P. ADDRESS		24Q. DATE		24R. NAME OF REGISTRAR	
24S. FUNERAL DIRECTOR		24T. ADDRESS		24U. DATE	
24V. NAME OF REGISTRAR		24W. FUNERAL DIRECTOR		24X. ADDRESS	
24Y. DATE		24Z. NAME OF REGISTRAR		24AA. FUNERAL DIRECTOR	
24AB. ADDRESS		24AC. DATE		24AD. NAME OF REGISTRAR	
24AE. FUNERAL DIRECTOR		24AF. ADDRESS		24AG. DATE	
24AH. NAME OF REGISTRAR		24AI. FUNERAL DIRECTOR		24AJ. ADDRESS	
24AK. DATE		24AL. NAME OF REGISTRAR		24AM. FUNERAL DIRECTOR	
24AN. ADDRESS		24AO. DATE		24AP. NAME OF REGISTRAR	
24AQ. FUNERAL DIRECTOR		24AR. ADDRESS		24AS. DATE	
24AT. NAME OF REGISTRAR		24AU. FUNERAL DIRECTOR		24AV. ADDRESS	
24AW. DATE		24AX. NAME OF REGISTRAR		24AY. FUNERAL DIRECTOR	
24AZ. ADDRESS		24BA. DATE		24BB. NAME OF REGISTRAR	
24BC. FUNERAL DIRECTOR		24BD. ADDRESS		24BE. DATE	
24BF. NAME OF REGISTRAR		24BG. FUNERAL DIRECTOR		24BH. ADDRESS	
24BI. DATE		24BJ. NAME OF REGISTRAR		24BK. FUNERAL DIRECTOR	
24BL. ADDRESS		24BM. DATE		24BN. NAME OF REGISTRAR	
24BO. FUNERAL DIRECTOR		24BP. ADDRESS		24BQ. DATE	
24BR. NAME OF REGISTRAR		24BS. FUNERAL DIRECTOR		24BT. ADDRESS	
24BU. DATE		24BV. NAME OF REGISTRAR		24BW. FUNERAL DIRECTOR	
24BX. ADDRESS		24BY. DATE		24BZ. NAME OF REGISTRAR	
24CA. FUNERAL DIRECTOR		24CB. ADDRESS		24CC. DATE	
24CD. NAME OF REGISTRAR		24CE. FUNERAL DIRECTOR		24CF. ADDRESS	
24CG. DATE		24CH. NAME OF REGISTRAR		24CI. FUNERAL DIRECTOR	
24CJ. ADDRESS		24CK. DATE		24CL. NAME OF REGISTRAR	
24CM. FUNERAL DIRECTOR		24CN. ADDRESS		24CO. DATE	
24CP. NAME OF REGISTRAR		24CQ. FUNERAL DIRECTOR		24CR. ADDRESS	
24CS. DATE		24CT. NAME OF REGISTRAR		24CU. FUNERAL DIRECTOR	
24CV. ADDRESS		24CW. DATE		24CX. NAME OF REGISTRAR	
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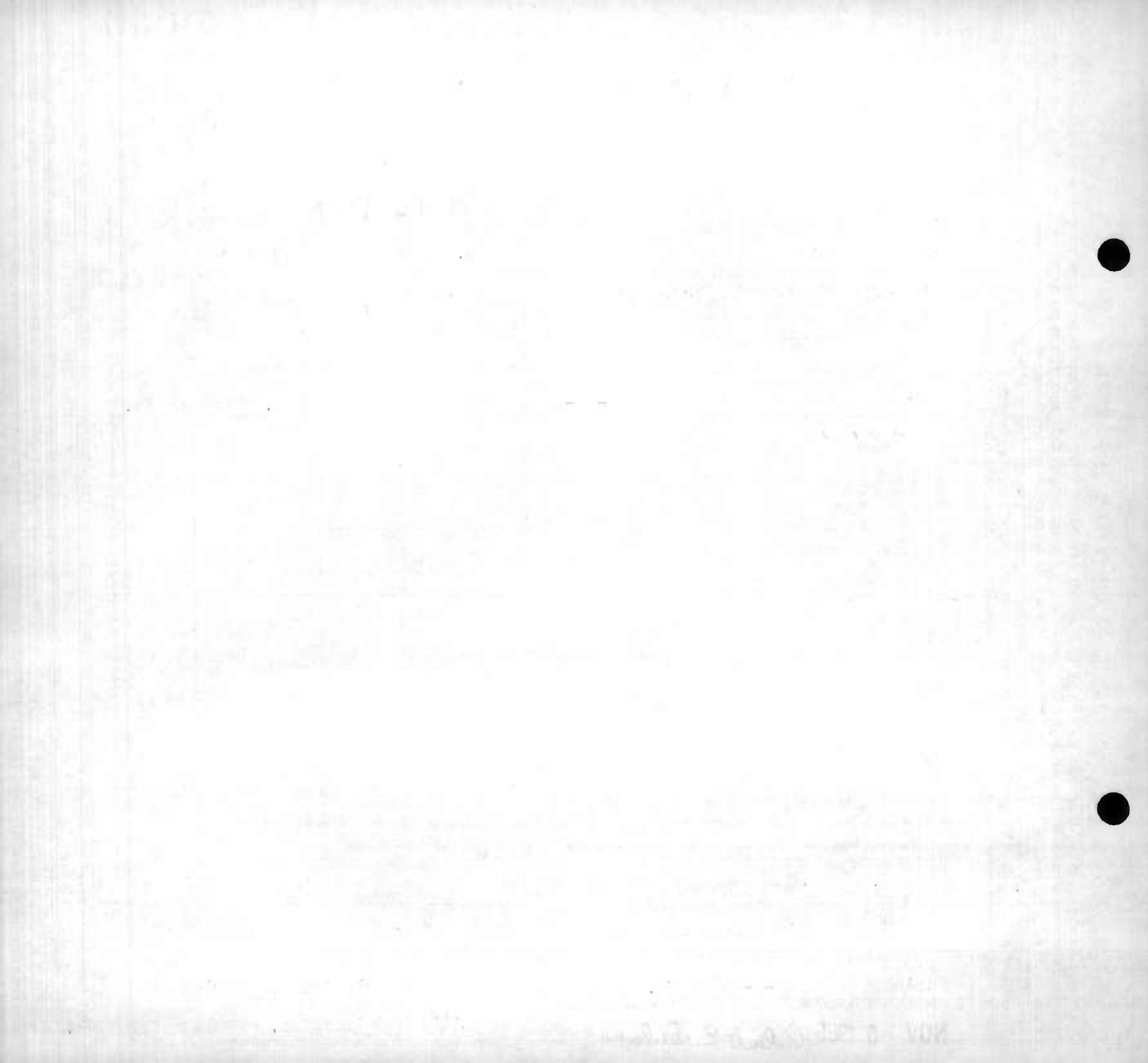




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11347		CERTIFICATE OF DEATH		Registered No. 65 11347	
1. NAME OF DECEASED (Type or Print) <b>DRYDEN, NORMAN C.</b>				2. DATE AND HOUR OF DEATH <b>11-3-1965 9 45 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>7 MERCY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>7-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3016 E. Monument St.</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>		8. DATE OF BIRTH <b>Feb. 2, 1912</b>		9. AGE (In years last birthday) <b>53</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pile Driver</b>		11. BIRTHPLACE (State or foreign country) <b>Christfield, Maryland</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Ernest Dryden</b>				14. MOTHER'S MAIDEN NAME <b>Ina Webb</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-01-2181</b>		17. INFORMANT <b>Mary Dryden</b>			ADDRESS <b>3016 E. Monument St.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Hepatic insufficiency</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Laemec cirrhosis</b>				INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>9-29-1965</b> 19 <b>11-3-</b> 19 <b>65</b> , that (I) <del>was</del> lost saw the deceased alive on <b>11-3-</b> 19 <b>65</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.									
23A. SIGNATURE <b>Joseph Notarangelo</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-3-1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH NOTARANGELO</b> M.O.				23D. ADDRESS <b>MERCY HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-6-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Carmel</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11348		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11348	
M.E. CASE NO. <del>WILLIAM W. BURFORD</del>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WILLIAM W. BURFORD, SR.</u>		2. DATE AND HOUR OF DEATH <u>11/4/65 2:25 AM</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>25-52</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hosp. Baltimore, Md.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1908 Caspell Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>11/28/03</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William A. Burford</u>		14. MOTHER'S MAIDEN NAME <u>Grace Wallace</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-4693</u>		17. INFORMANT ADDRESS <u>Hosp. Chant.</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Primary Carcinoma of lung &amp; Metastasis to brain &amp; spine.</u> (B) DUE TO <u>Spine.</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> 19 <u>65</u> to <u>11/4</u> 19 <u>65</u> . that (I) (we) last saw the deceased alive on <u>11/4</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Stephen Margolis</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/4/65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <u>Maryland General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/28/03</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Hubbard Funeral Home</u>		ADDRESS <u>4107 Wilkens Ave.</u>			

20

11/11/1962

EPH-20-113

62

11/11

Worship General Meeting  
Catholic Center, Baito, Ind.  
Nov 11, 1962 (P. 113)

BIRTH NO. 65 11349

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11349

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RUSSELL COLE

2. DATE AND HOUR PRONOUNCED DEAD

November 3, 1965

1:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3917 Stokes Drive

21230

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

APRIL 19, 1900

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

MACHINIST

10B. KIND OF BUSINESS OR INDUSTRY

BETHLEHAM STEEL

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JUDSON COLE

14. MOTHER'S MAIDEN NAME

MARGARET????????

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW XXXX I

16. SOCIAL  
SECURITY NO.

UNKNOWN

17. INFORMANT

ADDRESS

MAE COLE 3917 STOKES DRIVE 21229

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11/6/1965

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEMETERY

23D. LOCATION

(City, town, or county)

BALTIMORE,

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

NOV 8 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

ADDRESS

HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229

VALLEY POLICE

140 COMMUNITY

*Handwritten signature*

1992



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No.	
BIRTH NO.		65 11350		65 11350	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		JOHN J. COOLAHAN JR.		2. DATE AND HOUR OF DEATH Nov. 2, 1965 3:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		BALTIMORE	
2055 GRIFFISS AVENUE 21230		2055 GRIFFISS AVENUE 21230			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/28/1899	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY R. E. A.	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK COOLAHAN		14. MOTHER'S MAIDEN NAME CATHERINE HOMIDINGER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS MRS. MARY A. COOLAHAN 2055 GRIFFISS AVENUE #30	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CONGESTIVE HEART FAILURE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.		CAUSE OF DEATH (A) DUE TO Acute congestive heart failure (B) DUE TO Arteriosclerotic C.V.D. (C) DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cirrhosis of the liver					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/12/52 to 11/2/65 that (I) (we) lost saw the deceased alive on 1/19/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert J. Levickas M.D.				23B. DATE SIGNED 11/4/65	
23C. PHYSICIAN'S NAME (Type) Herbert Levickas M.D.				23D. ADDRESS 1073 Maiden Choice Lane	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/5/65		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. NOV 8 1965		24F. NAME OF REGISTRAR Robert E. Faldut	
24G. FUNERAL DIRECTOR HUBBARD FUNERAL HOME 4107 WILKENS AVENUE #29		24H. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">65 11351</span>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">65 11351</span>	
M.E. CASE NO.				CERTIFICATE OF DEATH		P. M.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		1500	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Md Baltimore 25-30		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1322 Shilbark Rd	
5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 8				8. DATE OF BIRTH 9/24/64		9. AGE (In years, first birthday) 14y	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Walter Hines			
14. MOTHER'S MAIDEN NAME Irene Hackett				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Irene Hackett - 1322 Shilbark Rd.			
18. 1340.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Pending autopsy (B) Meningococcal (C)		INTERVAL BETWEEN ONSET AND DEATH ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED White Al Work <input type="checkbox"/> Not White Al Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11/5/65 1965 to 11/5/65 1965 that (I) (we) last saw the deceased alive on 11/5/65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE V.R. Blake M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED 11/5/65	
23C. PHYSICIAN'S NAME (Type) V.R. BLAKE		23D. ADDRESS 1514 Division St., Balto, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/65	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION Balto, Md.		25A. DATE REC'D BY HEALTH/DEPT. NOV 8 1965		25B. NAME OF REGISTRAR Robert E. Farnham	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. FUNERAL DIRECTOR		25F. ADDRESS	
Earl Gilmore		1827 W. North Ave		Earl Gilmore		1827 W. North Ave	

at the end of the

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 11352		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11352	
1. NAME OF DECEASED (Type or Print) <b>FLORENCE CECILIA PAUTIS</b>				2. DATE AND HOUR OF DEATH <b>NOV. 3, 1965</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME + HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1-05</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>419 S. MADEIRA ST</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>2-7-1922</b>	9. AGE (In years last birthday) <b>43</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH TURKOS</b>				14. MOTHER'S MAIDEN NAME <b>?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218-01-7042</b>		17. INFORMANT <b>STANLEY PAUTIS 419 S. MADEIRA ST.</b>			
18. <b>443 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial C. V. D.</b> <b>Repeated Congestive Failure.</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1950</b> to <b>Nov 3 1965</b> , that (I) (we) last saw the deceased alive on <b>Oct. 26 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE <b>M. J. Jaworski</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/5/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>M. J. JAWORSKI</b>				23D. ADDRESS <b>2711 EASTERN Ave.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-6-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY CEM</b>		24D. LOCATION (City, town, or county) (State) <b>DUNDALK MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fadden</b>		25C. FUNERAL DIRECTOR <b>JOHN M WEBER + SONS INC 401 S. CHESTER ST</b>					

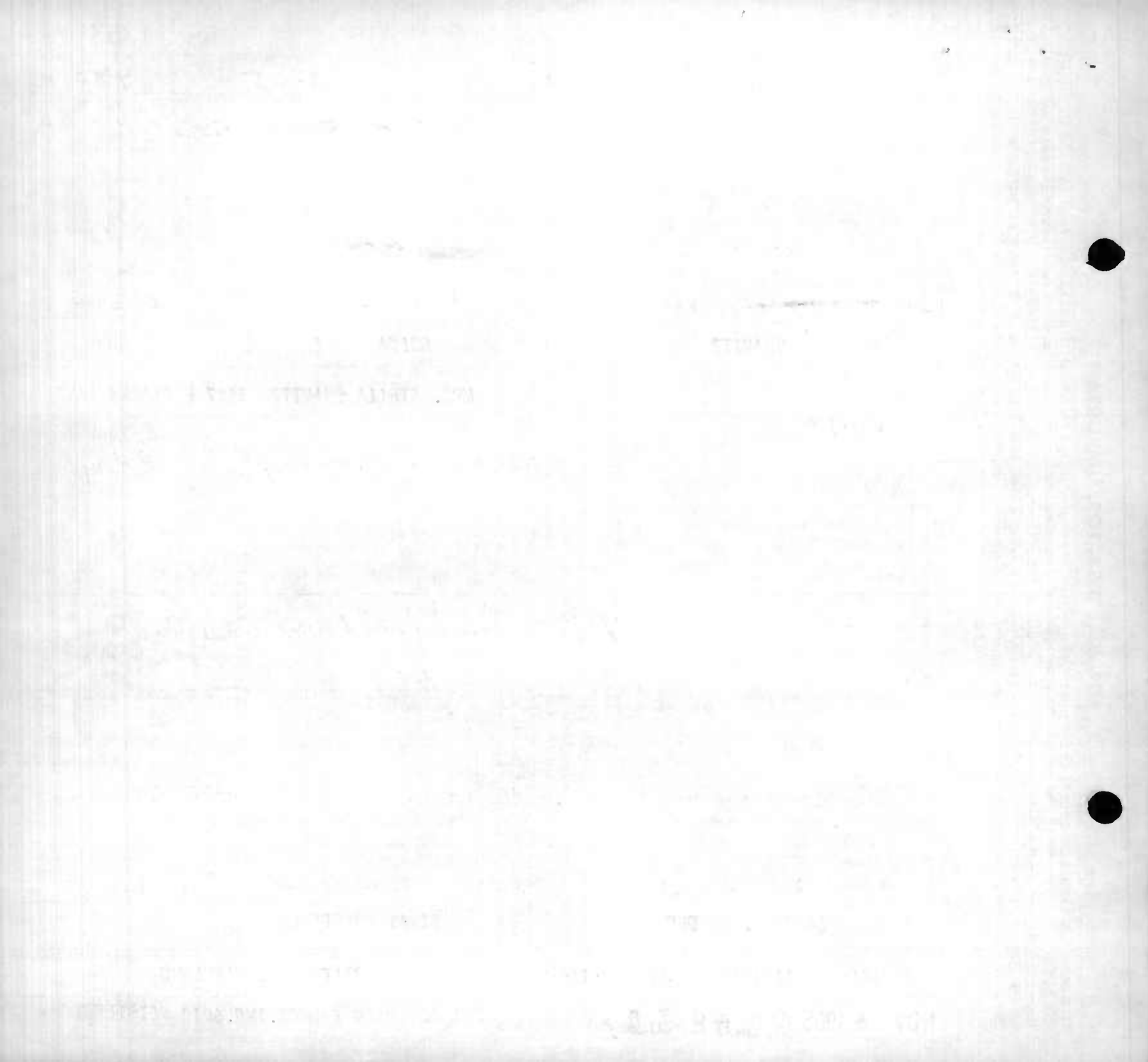


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11353	
BIRTH NO. 65 11353		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SA MUEL SHAVITZ</b>		2. DATE AND HOUR OF DEATH <b>11-3-65 4:50 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>MD</b> B. COUNTY <b>B. CLARKS LAKE</b>			
<b>SINAI HOSPITAL OF BALTO</b> <b>5000 GREENSPRING AVE</b> <b>BALTO. 15, MD</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<b>BALTIMORE 15</b>	
		D. STREET ADDRESS (If rural, give location)		<b>3927 B. CLARKS LAKE</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FURNITURE BUSINESS</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>EXECUTIVE</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>SHAVITZ</b>		14. MOTHER'S MAIDEN NAME <b>GOLDA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MRS. STELLA SHAVITZ 3927 B CLARKS LANE</b>	
18. <b>490X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>ACUTE PNEUMONIA</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>PARKINSON'S Disease, ARTERIOSCLEROTIC CARDIO-VASCULAR Disease</b>		<b>4 years 5 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-1-65</b> 19 to <b>11-3-65</b> 19 that (I) (we) last saw the deceased alive on <b>11-3-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Larry A. Snyder</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-3-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>LARRY A. SNYDER</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/4/65</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH TFILOH</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11354		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11354	
1. NAME OF DECEASED (Type or Print) <i>Simon Schultzy</i>			2. DATE AND HOUR OF DEATH <i>Nov. 3, 1965 3 PM M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>MD.</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Maryland</i>		
			D. STREET ADDRESS (If rural, give location) <i>3903 Barrington Road</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>11/11/80</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>GROCERY - RETAIL</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>GROCERY - RETAIL</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
13. FATHER'S NAME <i>ISAAC Schultzy</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT ADDRESS <i>Mrs. Evelyn Strumwater (daughter)</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>153.31</i>			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO <i>Generalized peritonitis 7 weeks</i>		
ANTECEDENT CAUSES			(B) DUE TO <i>Metastatic adenocarcinoma 4 years</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <i>of sigmoid colon</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Atherosclerotic Cardiovascular Disease &amp; CHF (Syst)</i>					
19A. DATE OF OPERATION <i>Sept 29/1965</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Generalized Peritonitis</i>		20A. AUTOPSY (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>9/18/65</i> 1965 to <i>11/3/65</i> 1965, that (I) <i>(we)</i> last saw the deceased alive on <i>11/3/65</i> 1965 and that in my <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>George Banks</i>			23B. DATE SIGNED <i>11/3/65 3PM</i>		
23C. PHYSICIAN'S NAME (Type) <i>George BANKS</i>			23D. ADDRESS <i>SINAI Hospital, Baltimore</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11/4/65</i>		24C. NAME of CEMETERY or CREMATORY <i>BETH TFILOH</i>	
24D. LOCATION (City, town, or county) <i>BALTIMORE MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fidler</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</i>			



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **65 11355** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 11355**

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)**LILLIAN WEINBERG**

2. DATE AND HOUR PRONOUNCED DEAD

**11/1/65 16:50 p. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)**Sinai Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**Maryland**

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**5801 Rubin Ave.**

5. SEX

**female**

6. RACE

**white**7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday) **73**If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)**HOUSEWIFE**

10B. KIND OF BUSINESS OR INDUSTRY

**AT HOME**

11. BIRTHPLACE (State or foreign country)

**BALTIMORE, MARYLAND**12. CITIZEN OF  
WHAT COUNTRY?**USA**

13. FATHER'S NAME

**ISRAEL COHEN**

14. MOTHER'S MAIDEN NAME

**UNKNOWN**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)**NO**16. SOCIAL  
SECURITY NO.**NO**

17. INFORMANT

ADDRESS

**MRS. HILDA CAPLAN 6902 BLANCHE AVENUE**

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) **Arteriosclerotic and hypertensive cardio-  
vascular disease**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)   
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

**no**20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)**Werner U. Spitz, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

**11/2/65**23A. BURIAL CREMATION,  
REMOVED**BURIAL**

23B. DATE

**11/3/65**

23C. NAME OF CEMETERY or CREMATORY

**BNAT ISRAEL**

23D. LOCATION

**BALTIMORE, MARYLAND**

(City, town, county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

**NOV 8 1965**

24B. NAME OF REGISTRAR

**Robert E. Farley, M.D.**

24C. FUNERAL DIRECTOR

**SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD**

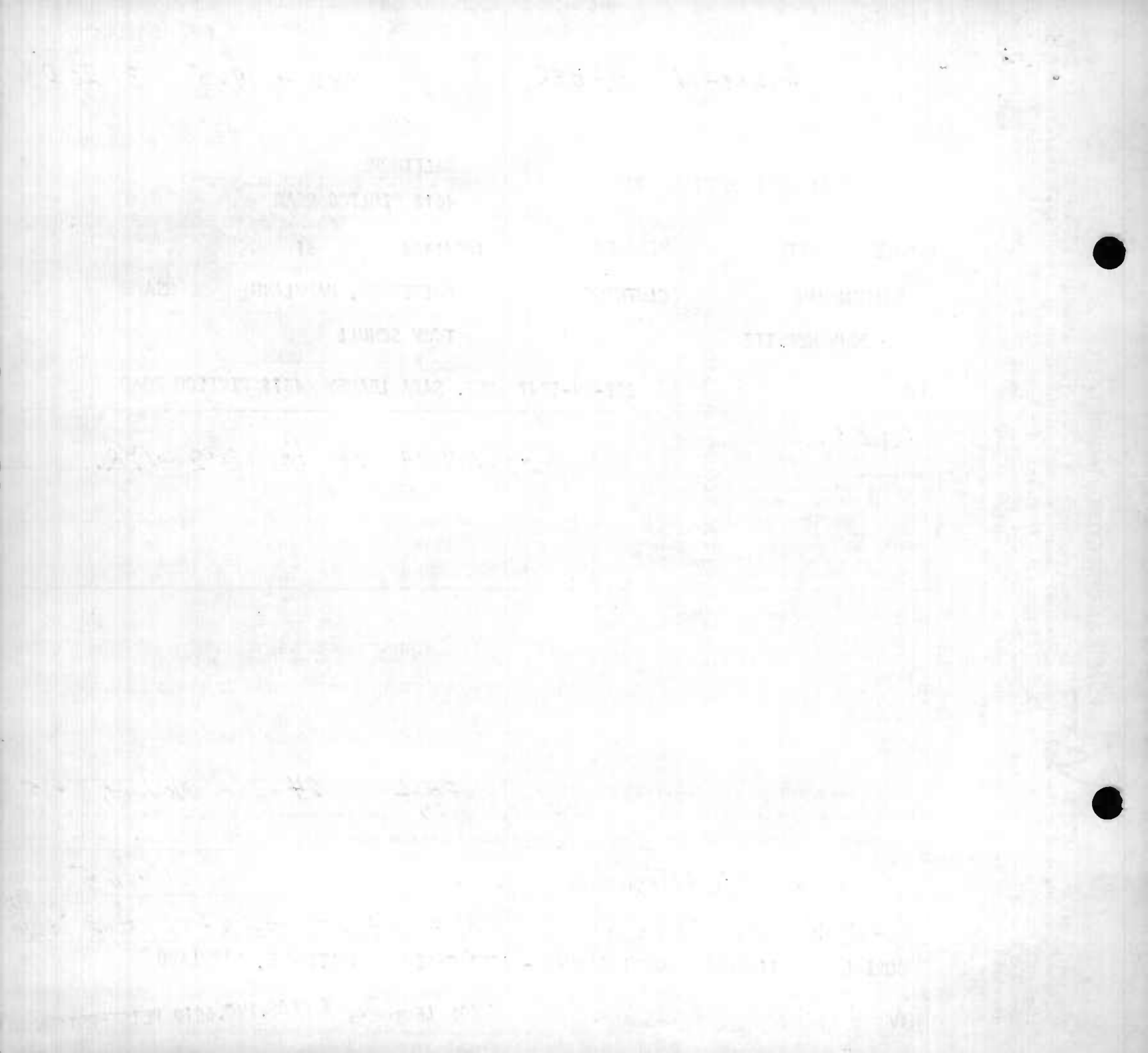
ADDRESS

AVAILABLE FOR RENT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11356	
BIRTH NO. 65 11356		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>LILLIAN HABER</b>		2. DATE AND HOUR OF DEATH <b>Nov. 4, 1965 3:20 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>PALL MALL NURSING HOME</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-16</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4618 PIMLICO ROAD</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>4/2/1904</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>JOHN HORWITZ</b>		
14. MOTHER'S MAIDEN NAME <b>TOBY SCHULL</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>052-88-5247</b>			17. INFORMANT ADDRESS <b>MRS. SARA LEAVEY 4618 PIMLICO ROAD</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>157X I CARCINOMA OF PANCREAS 1YR.</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1YR.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>FALL 1964</b> to <b>Nov. 4, 1965</b> , that (I) (we) last saw the deceased alive on <b>Nov. 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marvin Goldstein</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>11/4/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARVIN GOLDSTEIN</b>		23D. ADDRESS M.D. <b>5334 LIBERTY HEIGHTS AVE. BALTO, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/5/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>ANSHE EMUNAH - AITZ CHAIM</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Finkler, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>			

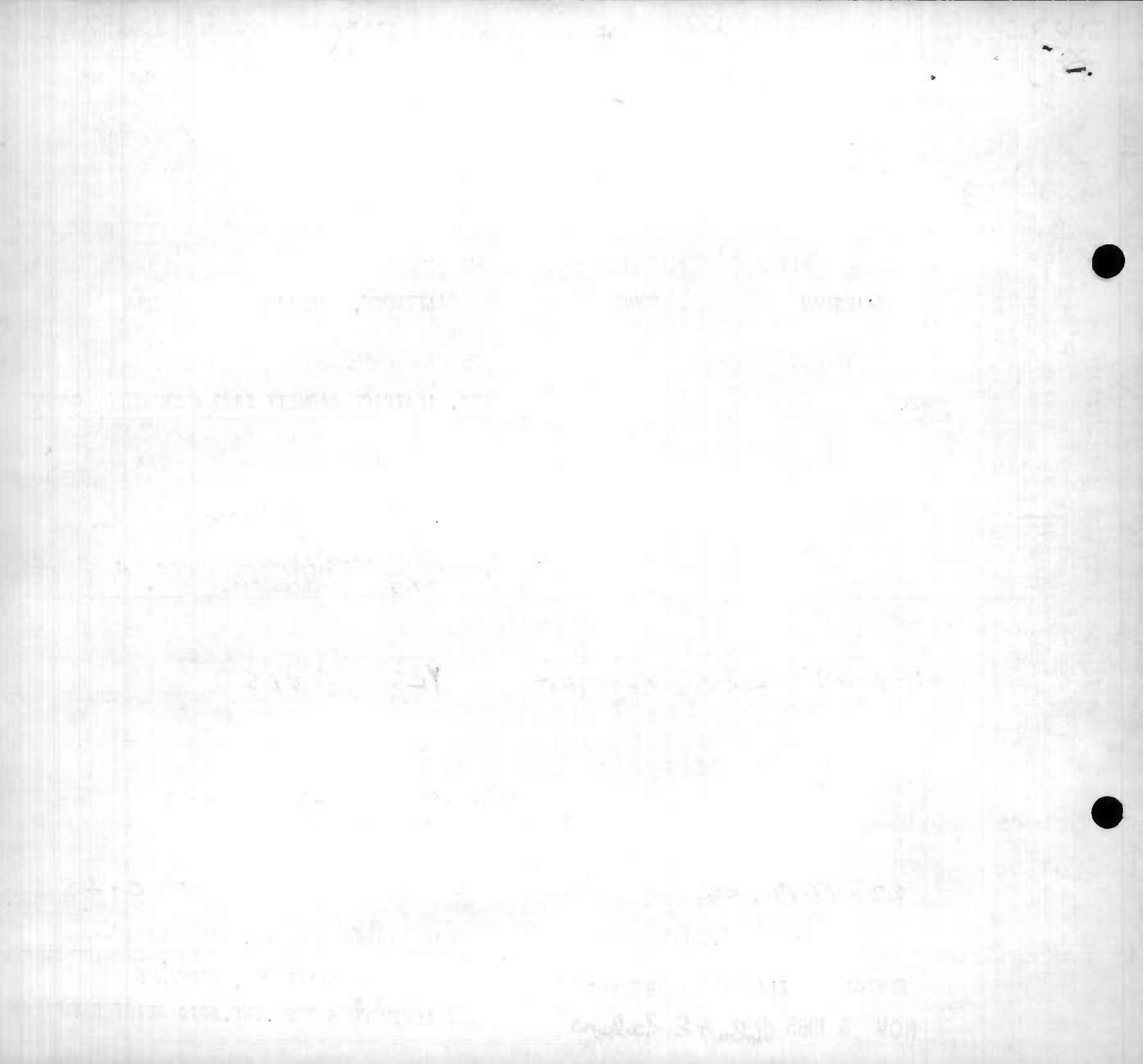




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11357	
BIRTH NO. 65 11357		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <i>BARNETT, Donald</i>					
1. NAME OF DECEASED (Type or Print) <i>BARNETT, DONALD ARTHUR</i>		2. DATE AND HOUR OF DEATH <i>11-3-65 10:30 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>THE JOHNS HOPKINS HOSPITAL</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>2909 CHOREBERRY COURT</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>2-25-29</i>	9. AGE (In years last birthday) <i>36</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>DRUG</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>ISAAC BARNETT</i>			
14. MOTHER'S MAIDEN NAME <i>ESTHER PAULSON</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>MRS. LEATRICE BARNETT 2909 CHOREBERRY COURT</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>200.1</i>		CAUSE OF DEATH (A) <i>CARDIAC ARREST</i> DUE TO (B) <i>RESPIRATORY FAILURE</i> DUE TO (C) <i>POST OP RESECTION LYMPHOSARCOMA OF THE NECK</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 mins</i> <i>10 mins</i> <i>24 hrs</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>11-2-65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>LYMPHOSARCOMA</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>WHERE DID INJURY OCCUR?</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>11-2-65</i> 19 <i>65</i> to <i>11-3-</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>11-3-65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James H. Haycer MD</i>		23B. DATE SIGNED <i>11-3-65</i>		23C. PHYSICIAN'S NAME (Type) <i>JAMES H. HAYCER M.D.</i>	
23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11/5/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>HEBREW FRIENDSHIP</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</i>	



BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LILLIAN LEVY BOWIE

2. DATE AND HOUR PRONOUNCED DEAD

11-1-65

2:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
address or location)

1204 McCULLOH STREET

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1204 McCulloh Street 21217

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
Single

8. DATE OF BIRTH

Aug. 9- 1914

9. AGE (In years  
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

\*\*\*\*\*

11. BIRTHPLACE (State or foreign country)

A.A.Co. Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Lucy McGowan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
Unknown

17. INFORMANT

ADDRESS

Elizabeth Duvall-1904 West St. Annapolis, Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchopneumonia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-1-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Nov. 4-65

23C. NAME of CEMETERY or CREMATORY

Brewer Hill

23D. LOCATION

(City, town, or county)

(State)

Annapolis, Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 8 1965

24B. NAME OF REGISTRAR

Robert E. Fickel

24C. FUNERAL DIRECTOR

ADDRESS

C.E. Hicks 111 Annapolis, Maryland

WALLER POLICE

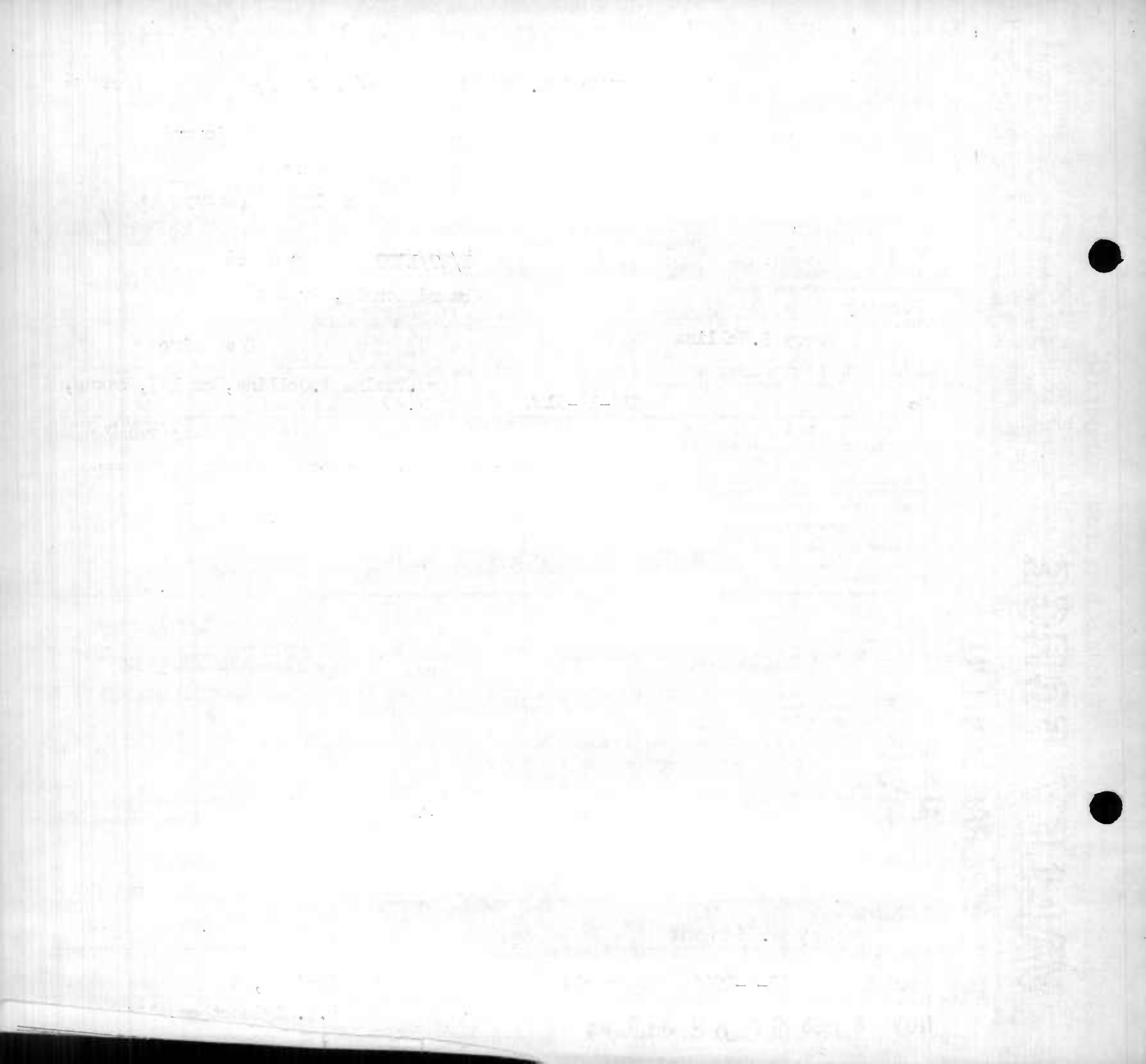
NO. 100-100000

100-100000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11359				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11359	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) Thomas L Collins				THOMAS L. COLLINS		11/6/65 1:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
University Hospital				Maryland Howard			
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Male Caucasian Married				Jessup Jessup 63-00			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				D. STREET ADDRESS (If rural, give location)			
Farming				Box 175 Jessup 175 Oakland Mills Road			
8. DATE OF BIRTH		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
1/27/1899		66 66		Howard County, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Harry L. Collins				Ida Dixon Ida Dixon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				216-18-5127		Mrs. Thelma L. Collins, Box 175, Jessup, Md Hospital Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		4 days	
ANTECEDENT CAUSES				(B) DUE TO		3 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Arteriosclerotic Cardiovascular disease		7 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Tuberculosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
X		While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		X			
22. I certify that (I) (this hospital) attended the deceased from 11-6-65 to 11-6-65, that (I) (we) last saw the deceased alive on 11-6-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Henry A. Saiontz						11-6-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Henry A. Saiontz							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11-9-1965		Meadowridge		Elkridge, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 8 1965		Robert E. Finkbeiner		F. C. Higinbotham		Ellicott City Md	



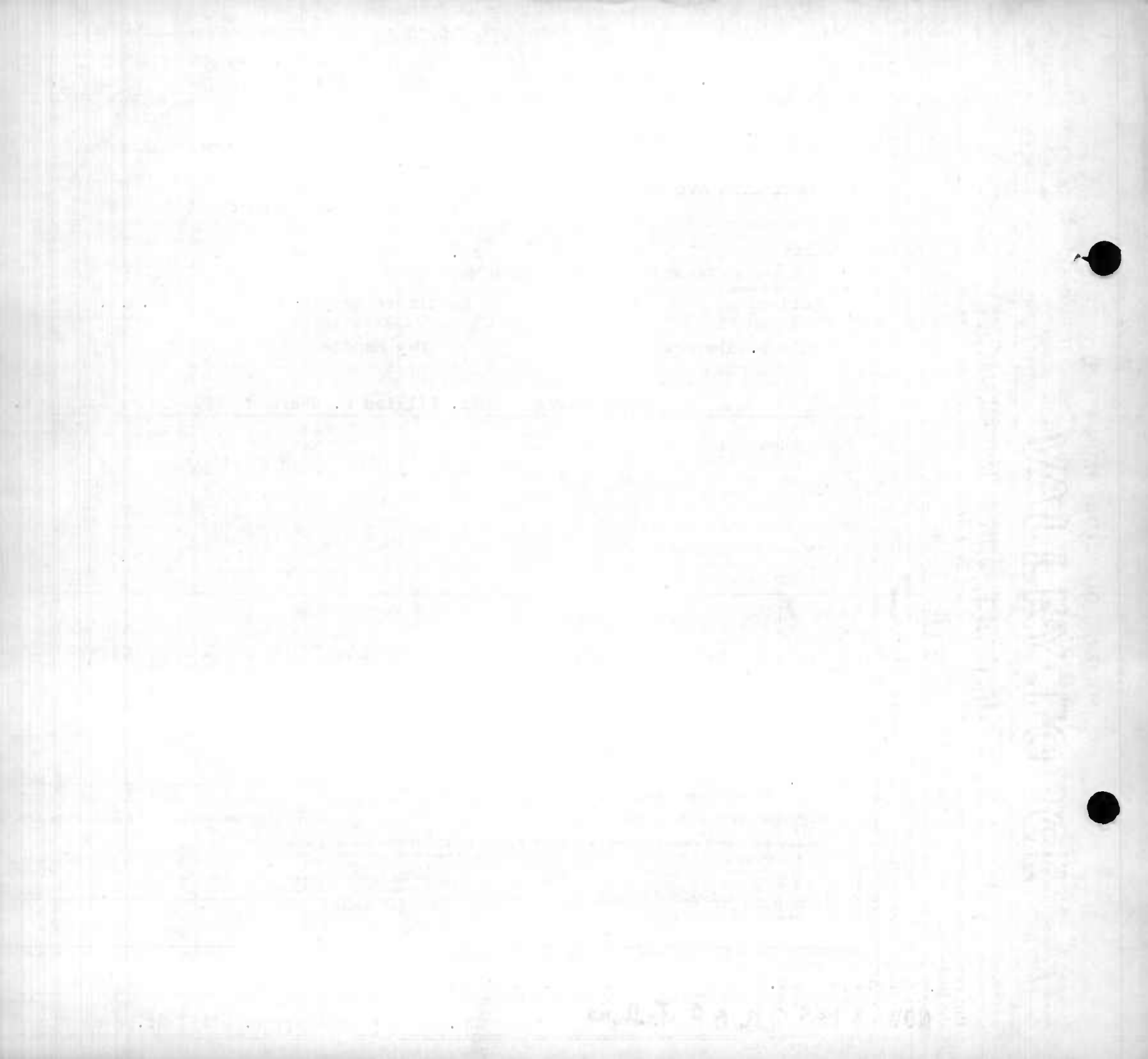


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11360	
BIRTH NO. 65 11360		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THOMAS H. SHERMAN		2. DATE AND HOUR OF DEATH November 4, 1965 5:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  3808 Tudor Arms Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3808 Tudor Arms Avenue (11)			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Mar. 3, 1896	9. AGE (in years lost birthday) 69	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis F. Sherman		14. MOTHER'S MAIDEN NAME May Hanson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-4268		17. INFORMANT ADDRESS Mrs. Lillian C. Sherman 3808 Tudor Arms Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO art sclerotic heart disease 10 yrs (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6/4 1955 to 11/4 1965, that (I) (we) lost saw the deceased alive on 11/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Mamuel Feldman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/5/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 2 E Read St, Balto md			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE Nov. 5, 1965		24C. NAME of CEMETERY or CREMATORY Greenmount Crematory	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965			
25B. NAME OF REGISTRAR Robert E. Feldman		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook - Brooks, Inc. 1217 St. Paul Street			





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11361</b>	
BIRTH NO. <b>65 11361</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>William Clark</b>		2. DATE AND HOUR OF DEATH <b>11-4-65</b> <b>10:40 a.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>7-05</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>841 North Washington Street</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5-7-10</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Oays If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe maker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GA.</b>	
13. FATHER'S NAME <b>Will Clark</b>		14. MOTHER'S MAIDEN NAME <b>Georgia Rodgers</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II 33 989550</b>		16. SOCIAL SECURITY NO. <b>263-24-6657</b>		17. INFORMANT <b>Susan D. Clark</b> ADDRESS <b>841 N. Washington</b>	
18. <b>286-7 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory arrest</b> ANTECEDENT CAUSES <b>Wernicke's encephalopathy</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>—</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>weeks</b>	
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>10/35</b> <b>19 65</b> to <b>11/4</b> <b>19 65</b> , that (I) (we) last saw the deceased alive on <b>11/4</b> <b>19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert I. Keimowitz</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/4/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert I. Keimowitz</b>		23D. ADDRESS <b>Johns Hopkins Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/8/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. National</b>	
24D. LOCATION <b>5501 Frederick Rd</b>		24E. (City, town, or county) <b>AL</b>		24F. (State) <b>AL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Joseph H. Locks Jr</b> ADDRESS <b>1304 N. Central Ave</b>	

1880

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and the quality of the scan.]*

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11362</b>	
BIRTH NO. <b>65 11362</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>John Duffy</b>		2. DATE AND HOUR OF DEATH <b>Nov 3 1965 1 5 11</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>13-08</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL Hospital</b> <b>Balto, Md.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>2158 David Park Drive</b>			
5. SEX <b>M</b>	6. RACE <b>Can</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9/8/89</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>Conn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Duffy</b>		14. MOTHER'S MAIDEN NAME <b>McGowan</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1st W.W.</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Wife</b> ADDRESS <b>SAME</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Acute Myocardial Infarct</b> DUE TO <b>ASCVD</b> (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 Hrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/3 1965</b> to <b>11/3 1965</b> , that (I) (we) last saw the deceased alive on <b>11/3 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ronald T. Lewers</b> M.D.		23B. DATE SIGNED <b>11/3/65</b>		23C. PHYSICIAN'S NAME (Type) <b>Ronald T. Lewers</b> M.D.	
23D. ADDRESS <b>Maryland General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/6/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>		25C. FUNERAL DIRECTOR <b>Austin E. Donovan</b> 3818 Highland Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11363				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11363	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BENNER, VERNON				A. S.		NOVEMBER 6, 1965   8:55 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. # 29				A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)				B. COUNTY			
5. SEX MALE				6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	
8. DATE OF BIRTH 11-30-48				9. AGE (In years lost birthday) 16		10. If Under 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME VERNON M. BENNER				14. MOTHER'S MAIDEN NAME ELNORA Adelaide S. Sparrow			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE				16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS ST. AGNES HOSP. RECORDS-WILKENS & CATON AVES.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Chronic glomerulonephritis with severe renal failure and. (B) DUE TO Uremia. (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 28 19 65 to NOVEMBER 6 19 65, that (I) (we) last saw the deceased alive on NOVEMBER 6, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rafael Marin				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/6/65	
23C. PHYSICIAN'S NAME (Type) RAFAEL MARIN				23D. ADDRESS CATON & WILKENS AVES. #29			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-9-65		24C. NAME of CEMETERY or CREMATORY London Park		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Geo L. Schwab		ADDRESS 2101 Fredrickline	

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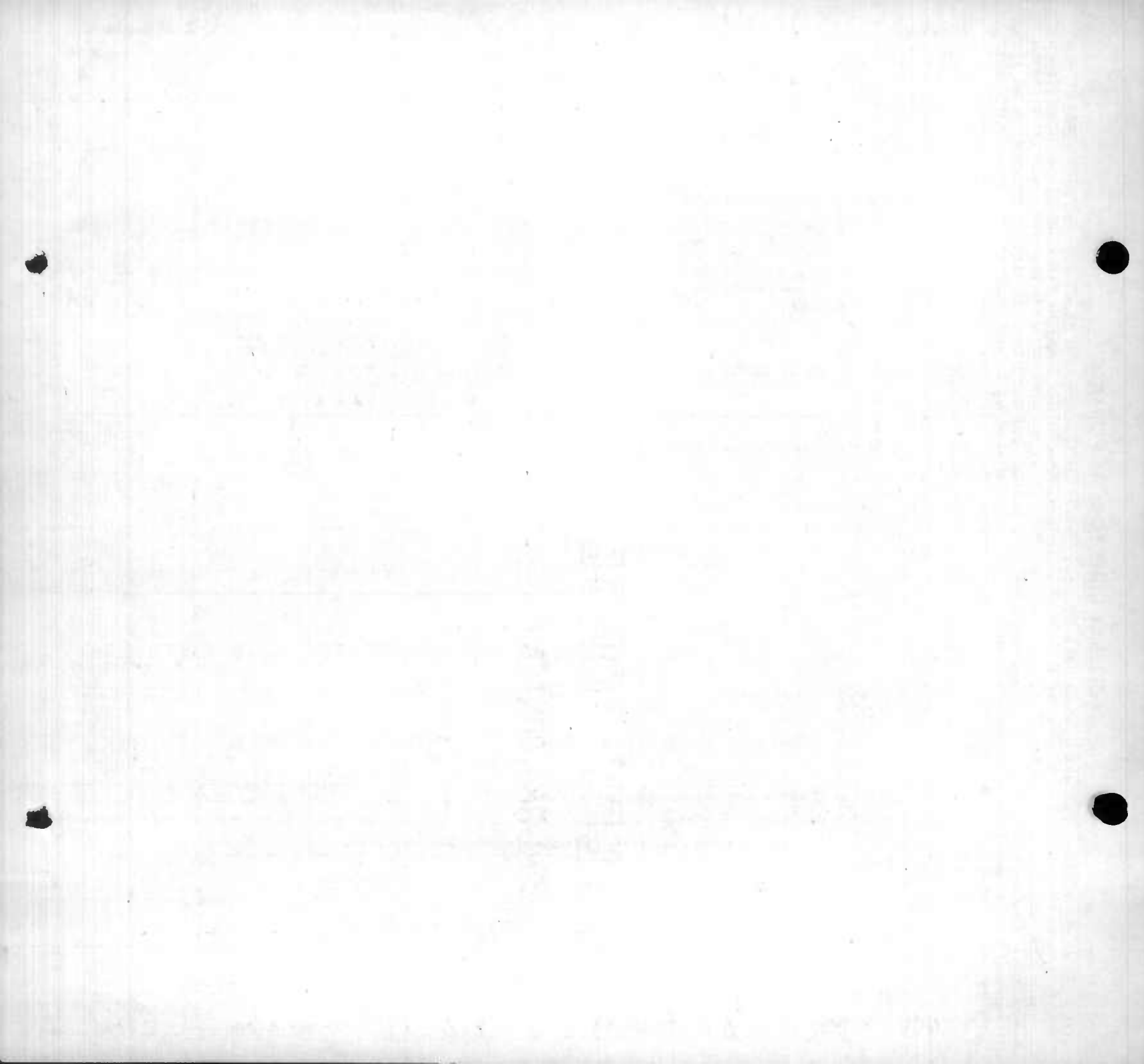
NOV 22 1962



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

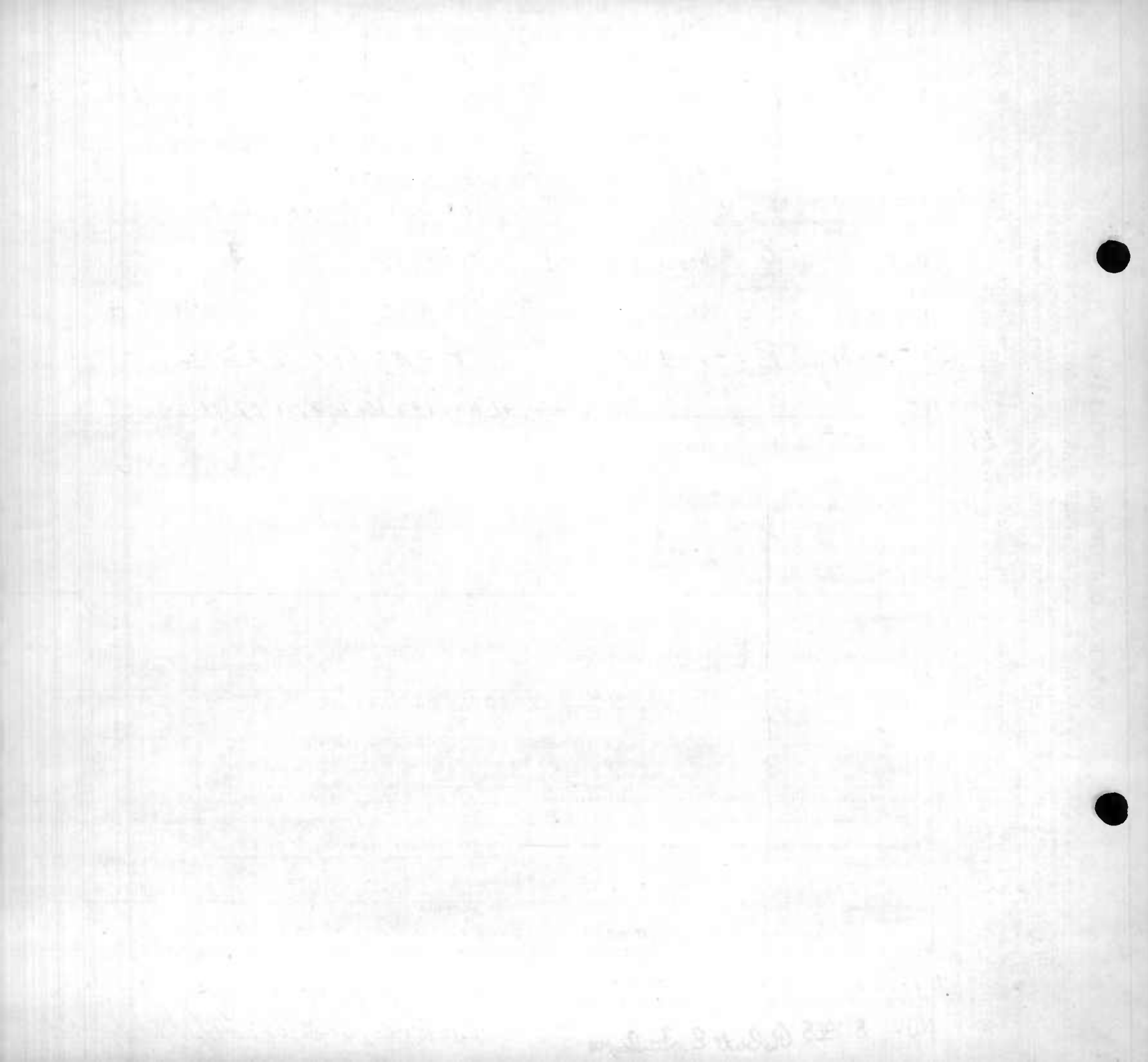
BIRTH NO. <b>65 11364</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11364</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM JOHN ROTH</b>		2. DATE AND HOUR OF DEATH <b>11-4-65 5:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>FRANKLIN SQUARE HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>127 JAMES ST.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. <del>MARRIED</del> , NEVER MARRIED <del>WIDOWED</del> , DIVORCED (specify)	8. DATE OF BIRTH <b>1/10/03</b>	9. AGE (In years lost birthday) <b>62</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRACKMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
13. FATHER'S NAME <b>JOHN ROTH</b>			14. MOTHER'S MAIDEN NAME <b>MARY BOHZA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>EDNA LANE 127 JAMES BALT. MD.</b>	
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>@ of lungs, terminal</b> DUE TO (B) DUE TO (C) 		INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-4-1965</b> to <b>11-4-1965</b> , that (I) (we) last saw the deceased alive on <b>11-4-1965</b> and that in (my) (our) opinion death occurred on the <b>11-4-1965</b> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. R. de Boya</b>				23B. DATE SIGNED <b>11-4-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JACINTO V. DE BOYA</b>				23D. ADDRESS <b>Franklin Square Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/8/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Pitohie Hwy Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>John J. Cowan Son Inc.</b>			
25D. ADDRESS <b>921 Hollins St. 23, Md.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11365				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11365	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WALLACE PIETROSKI				2. DATE AND HOUR OF DEATH Nov. 3, 1965 9 12 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL BALTIMORE, MARYLAND				A. STATE B. COUNTY Maryland 19-04			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 118 S. Gilmore St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH Sept 29, 1902	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10B. KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME Stanley Pietrowski				14. MOTHER'S MAIDEN NAME Anna Grinbas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 015-03-43779		17. INFORMANT ADDRESS Charles KORSKI 121 Maiden Choice			
18. 053.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) SEPTICEMIA, ETIOLOGY UNKNOWN DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/16/65 to 11/3/65, that (I) (we) last saw the deceased alive on 11/3/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Martin C. Shargel				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/3/65	
23C. PHYSICIAN'S NAME (Type) MARTIN C. SHARGEL M.D.				23D. ADDRESS UNIVERSITY OF MARYLAND HOSP.			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11/8/65		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Cheentowaga, New York	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ambrose, Inc. 1328 Sulphur Sp. Rd.		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO. 65 11366		CERTIFICATE OF DEATH		Registered No. 65 11366	
1. NAME OF DECEASED (Type or Print) <b>Theresa C. Geyer</b>				2. DATE AND HOUR OF DEATH <b>4 - Nov 1965 2 40 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND General Hospital</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>26-08</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN <b>BALTIMORE</b>		(If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location) <b>3412 Gough St #24</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>		8. DATE OF BIRTH <b>4-12-81</b>		9. AGE (In years last birthday) <b>84</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>OTTO</b>				14. MOTHER'S MAIDEN NAME <b>Caroline (unknown)</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bernard Geyer, 4351 Sheldon Ave</b> <b>Hospital Chart - Taken From</b>			
18. <b>416X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Embolus To Cerebral Arteries</b> DUE TO (B) <b>Chronic Atrial Fibrillation</b> DUE TO (C) <b>Rheumatic Heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>AT Least 18 years</b> <b>Unknown</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from <b>30-Oct-1965</b> to <b>5-Nov-1965</b> , that (we) lost saw the deceased alive on <b>5-Nov-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>T.C. Cullis</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-Nov-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>T.C. Cullis</b>				23D. ADDRESS <b>MARYLAND General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/8/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Schlimmer Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane #13</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11368		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65 11368	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>AL FREDA MAXINE FINCEY</b>			2. DATE AND HOUR OF DEATH <b>11-4-65 6:35 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>FRANKLIN SQUARE HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>FOL</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1023 S. KENWOOD AVE.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>1/2-25</b>	9. AGE (In years lost birthday) <b>40</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b> <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Betty Mills Tavern</b>		11. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>ELBERT GAMBLE</b>		
14. MOTHER'S MAIDEN NAME <b>VERA SLYER</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>George H. Fincey, Above, Husband</b> <b>MEDICAL RECORD</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <b>CA, BREAST C</b> <b>multiple metastasis,</b> <b>Tumoral</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <b>8 mon.</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-23 1965</b> to <b>11-4 1965</b> , that (I) (we) lost saw the deceased alive on <b>11-4 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. V. de Borna</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>11-4-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JACINTO V. DE BORNA</b>		23D. ADDRESS <b>FRANKLIN SQUARE HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/8/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>2601-03-05 E. Madison Street #5</b>			

ALBANY, N. Y. 1881

THE ALBANY FREE PRESS

211 AD

ALBANY, N. Y. 1881

ALBANY, N. Y. 1881

ALBANY, N. Y. 1881

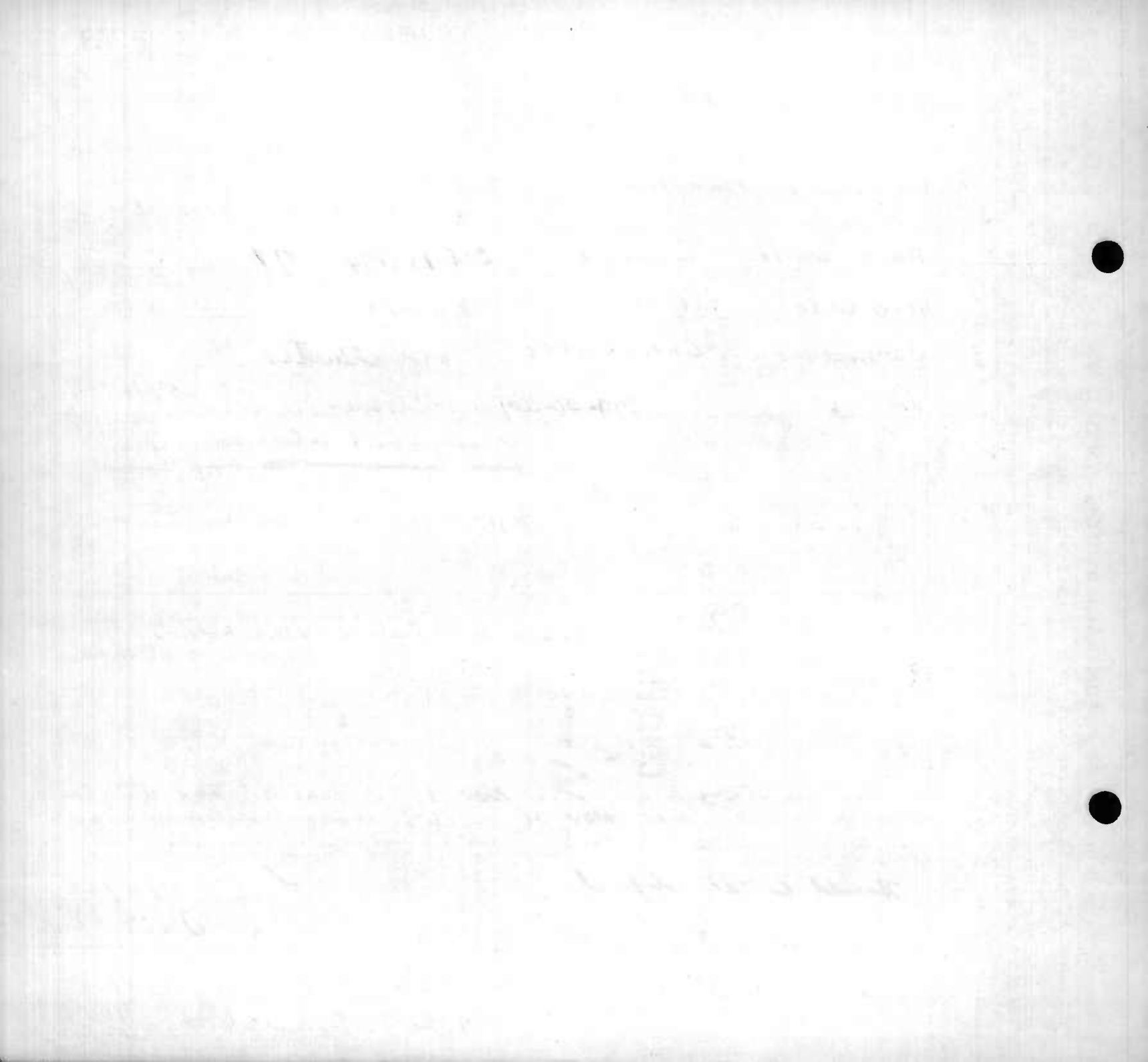
ALBANY, N. Y. 1881

ALBANY, N. Y. 1881

# FUNERAL DIRECTOR: IMPORTANT

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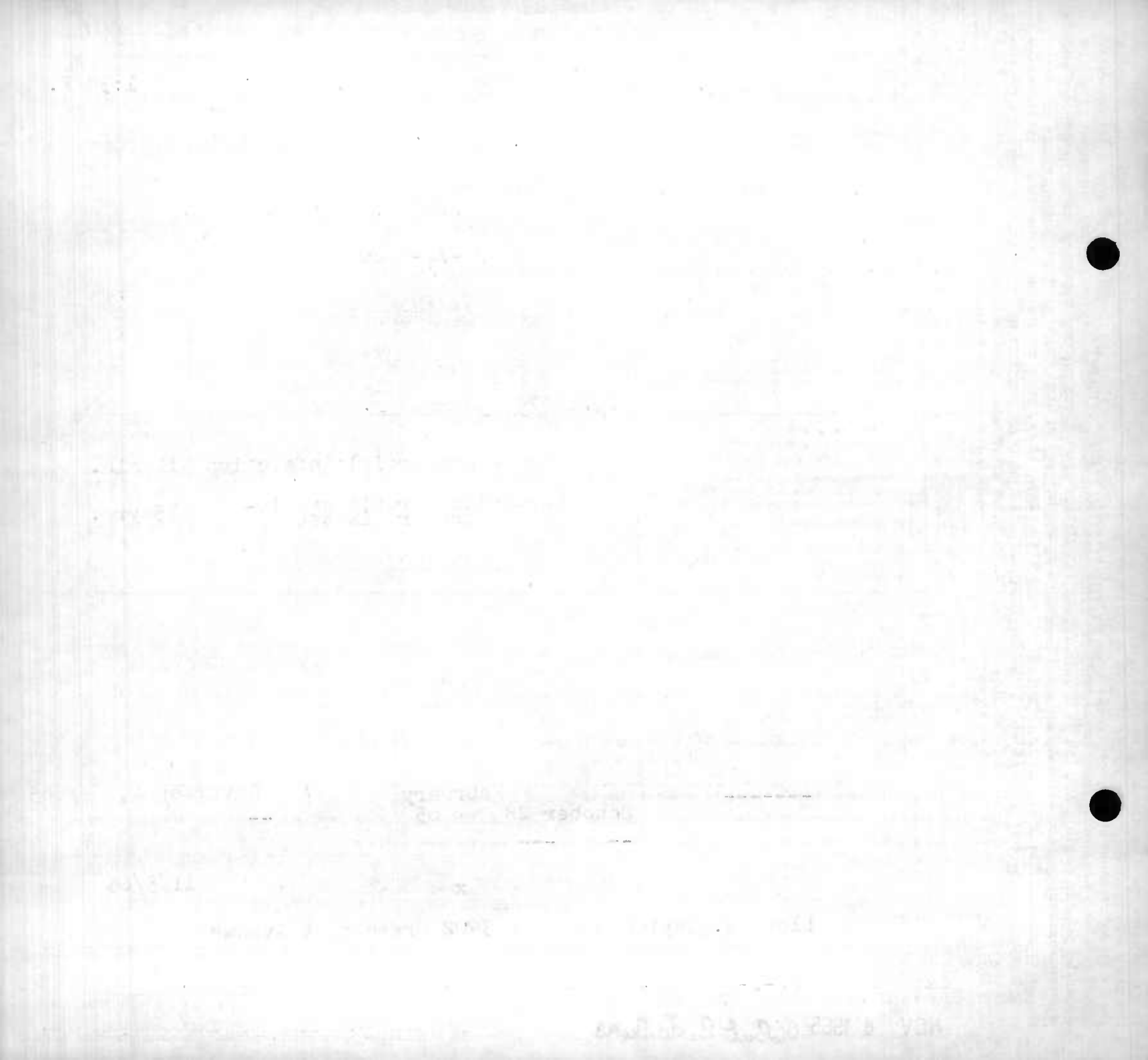
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 11369</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 11369</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Sinkas, Patricia Skella</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">Nov 4, 1965 8 40 A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.1em;">University Hosp. 38 Baltimore Maryland</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">18-03</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.1em;">Baltimore City</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.1em;">814 West Lombard St</span>		
5. SEX <span style="font-size: 1.1em;">Female</span>	6. RACE <span style="font-size: 1.1em;">White</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.1em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.1em;">Oct 15 1924</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">41</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">House wife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">at Home</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Lithuania Europe</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">USA</span>			13. FATHER'S NAME <span style="font-size: 1.1em;">John Chermaskes</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Mary Gustis</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">217-26 369</span>			17. INFORMANT <span style="font-size: 1.1em;">Mrs Stella Giardina</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.1em;">Congestive Heart Failure &amp; Severe Anemia</span>			CAUSE OF DEATH (A) <span style="font-size: 1.1em;">Urinary tract infection</span> DUE TO (B) <span style="font-size: 1.1em;">Hypernephroma suspected</span> DUE TO (C) <span style="font-size: 1.1em;">3 years</span>		
19A. DATE OF OPERATION <span style="font-size: 1.1em;">2 None</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">Yes</span>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">Nov 1</span> 19 <span style="font-size: 1.1em;">65</span> to <span style="font-size: 1.1em;">Nov 4</span> 19 <span style="font-size: 1.1em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">Nov 4</span> 19 <span style="font-size: 1.1em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.1em;">Harold C Standiford</span> M.D.				23B. DATE SIGNED <span style="font-size: 1.1em;">11/4/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">HAROLD C. STANDIFORD</span> M.D.				23D. ADDRESS <span style="font-size: 1.1em;">University Hosp. Balto. Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">11/8/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Baltimore National Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">5301 Frederick Ave.</span>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">John J. Cowan &amp; Son Inc.</span>		25D. ADDRESS <span style="font-size: 1.1em;">29 Hollins St. 23, Md.</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <span style="font-size: 1.5em;">65 11370</span>		CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.5em;">65 11370</span>	
1. NAME OF DECEASED (Type or Print) <i>Anna E. Stewart</i>				2. DATE AND HOUR OF DEATH <i>Nov. 4, 1965</i>   <i>1:30 P. M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1100 E. Belvedere Ave. Apt. A</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-38</i>					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					
				D. STREET ADDRESS (If rural, give location) <i>1100 E. Belvedere Ave.</i>					
5. SEX <i>female</i>		6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>		8. DATE OF BIRTH <i>12-14-1880</i>		9. AGE (In years last birthday) <i>84</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Illinois</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Robert Jones</i>				14. MOTHER'S MAIDEN NAME <i>Emma Mayes</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>215185275</i>		17. INFORMANT <i>Granvel J. Stewart</i>			
				ADDRESS <i>same</i>					
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Acute myocardial infarction</i> DUE TO (B) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i> <i>15 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>February</i> 19 <i>54</i> to <i>November 4,</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>October 28</i> 19 <i>65</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.									
23A. SIGNATURE <i>Lloyd E. Saylor</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>11/5/65</i>					
23C. PHYSICIAN'S NAME (Type) <i>Lloyd E. Saylor</i>				23D. ADDRESS M.D. <i>3902 Greenmount Avenue</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>11-8-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Feltman</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc Baltimore, Md.</i>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11371				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11371	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Lillian V. Wilson</i>				2. DATE AND HOUR OF DEATH <i>11/3/65</i> <i>8</i> <sup>00</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i> <i>827 Linden Ave 21201</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>14-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>345 Robert St 21217</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>2-14-96</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jimmie Wilson</i>				14. MOTHER'S MAIDEN NAME <i>Emma Williams</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-22-8065</i>		17. INFORMANT <i>Hospital Chart</i>		ADDRESS	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO  (B) _____ DUE TO  (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/1</i> <i>19 65</i> to <i>11/3</i> <i>19 65</i> , that (I) (we) lost saw the deceased alive on <i>11/3</i> <i>19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John M. Steffy</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/4/65</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-7-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Cooper's Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Calvert Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Pinkey &amp; Sewell Co. Frederick Md.</i>			

7-11-62 11-2-62 2002-CC-21C

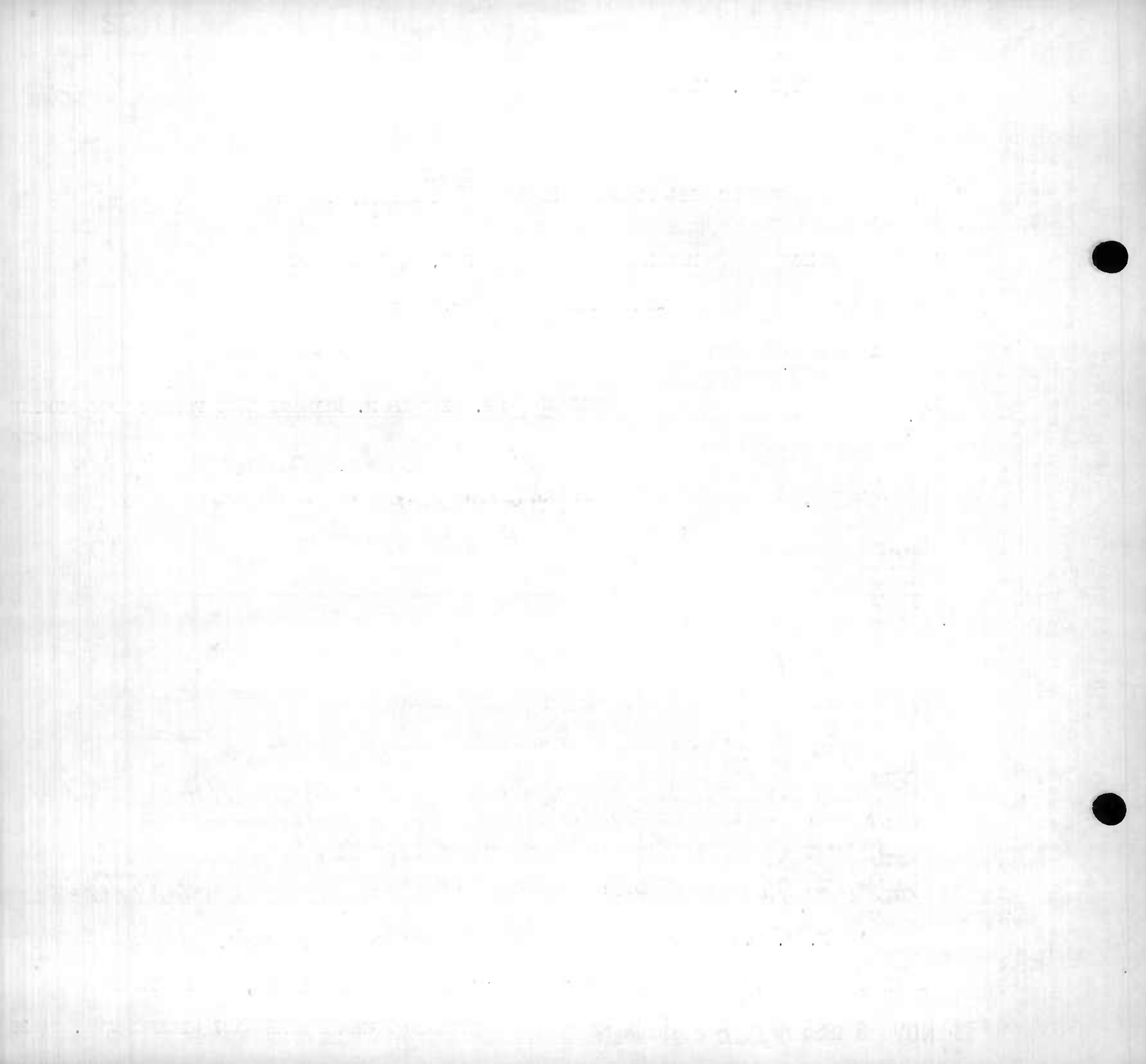
Collection 11-2-62

11-2-62 2002-CC-21C

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11372	
BIRTH NO.		65 11372		CERTIFICATE OF DEATH	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		EMILIE A. REIMANN		2. DATE AND HOUR OF DEATH 11/4/65 10 <sup>00</sup> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  1400 FOREST HILL AVENUE 21230		A. STATE MARYLAND		B. COUNTY BALTIMORE	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		D. STREET ADDRESS (If rural, give location)			
		1400 FOREST HILL AVENUE		21230	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JAN. 1, 1895	9. AGE (In years lost birthday) 70	10. Under 1 Yr. Months Days Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HEINRICH SCHLAUSCH		14. MOTHER'S MAIDEN NAME BERTHA-----	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MR. WILHELM H. REIMANN 1400 FOREST HILL AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Acute Cardiac Failure Cardiovascular Renal Disease (B) DUE TO Diabetes Mellitus (C) _____		INTERVAL BETWEEN ONSET AND DEATH 11/3/65 3yr 3yr	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/10 1965 to 11/4 1965, that (I) (we) last saw the deceased alive on 11/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph G. Laukaitis MD		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/5/1965	
23C. PHYSICIAN'S NAME (Type) J. G. Laukaitis		23D. ADDRESS 679 Washington Blvd. Baltimore 30 Md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/8/65		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229	



BIRTH NO. 65 11373 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

PETER P. PALLADI

2. DATE AND HOUR PRONOUNCED DEAD

November 5, 1965 12:10

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore (rural)

D. STREET ADDRESS (If rural, give location)

922 Francis Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

JUNE 29, 1920

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

BUILDER

10B. KIND OF BUSINESS OR INDUSTRY

BALTIMORE

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

GIUSEPPE PALLADI

14. MOTHER'S MAIDEN NAME

ADELE CORBELLI

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

YES

WW II

16. SOCIAL  
SECURITY NO.

218-12-7643

17. INFORMANT

VIVIAN W. PALLADI

ADDRESS

922 FRANCIS AVENUE #27

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive  
~~Heart Disease.~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Congenitally Small Coronary Arteries.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/5/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11/9/65

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

NOV 8 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

HUBBARD FUNERAL HOME 4107 WILKENS AVE. #29

VALLEY BOGE

WAGGON COMPANY

1911



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

**CERTIFICATE OF DEATH**

Registered No. **65 11374**

BIRTH NO.

**65 11374**

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

**Merritt C. Hunley**

2. DATE AND HOUR OF DEATH

**4 Nov. 1965**

**9:05 A.M.**

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

**1122 S. Potomac St.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

**Md. Balto.**

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

**Balto.**

D. STREET ADDRESS (If rural, give location)

**1122 S. Potomac St.**

5. SEX

**Male**

6. RACE

**White**

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

**Married**

8. DATE OF BIRTH

**15 No v. 05 59**

9. AGE (In years last birthday)

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Chauffer**

10B. KIND OF BUSINESS OR INDUSTRY

**Copper-Smelting**

11. BIRTHPLACE (State or foreign country)

**Cardinal, Mathew Co. Va.**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Henry Hunley**

14. MOTHER'S MAIDEN NAME

**Ruth L. White**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

**No**

**None**

16. SOCIAL SECURITY NO.

**216-03-3939**

17. INFORMANT

**Hunley**

ADDRESS

**Stella F. / 1122 S. Potomac St.**

18.

**157X I**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) **Carcinoma of Pancreas with Liver Metastases**

**6 mo.**

(B) DUE TO

(C) DUE TO

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

**No**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~this hospital~~ attended the deceased from **Sept. 13** 19 **65** to **Nov. 4** 19 **65**, that (I) ~~was~~ lost saw the deceased alive on **November 2** 19 **65** and that in (my) ~~own~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~was~~ (did not) view the body after death.

23A. SIGNATURE

**Clarence W. LeDoux**

M.D.

Attending Phys.

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

**11/5/65**

23C. PHYSICIAN'S NAME (Type)

**Clarence LeDoux**

M.D.

23D. ADDRESS

**3023 Eastern Ave.**

24A. BURIAL CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**Nov. 8, 1965**

24C. NAME OF CEMETERY or CREMATORY

**Sacred Heart of Jesus**

24D. LOCATION

**7401 German Hill Rd.**

**Balto. Co., Md.**

25A. DATE REC'D BY HEALTH DEPT.

**NOV 8 1965**

25B. NAME OF REGISTRAR

**Robert E. Johnson**

25C. FUNERAL DIRECTOR

**Marie Fialkowski 1000 S. KENWOOD**

ADDRESS





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11375				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11375	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Gordon H. Kraft</i>				2. DATE AND HOUR OF DEATH <i>11-5-65 10<sup>45</sup> P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<i>906116 Belair Rd.</i>		<i>Woodward St.</i>		<i>Md</i>		<i>21-01</i>	
5. SEX <i>Male</i>				6. RACE <i>White</i>			
7. MARRIED, NEVER MARRIED <i>single</i>				8. DATE OF BIRTH <i>7-26-19</i>			
9. AGE (In years last birthday) <i>46</i>				10. CITIZEN OF WHAT COUNTRY <i>USA</i>			
11. BIRTHPLACE (State or foreign country) <i>Md</i>				12. CITIZEN OF WHAT COUNTRY <i>USA</i>			
13. FATHER'S NAME <i>George Kraft</i>				14. MOTHER'S MAIDEN NAME <i>Emma</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW II</i>				16. SOCIAL SECURITY NO. <i>216017150</i>			
17. INFORMANT <i>Minna Melvin</i>				18. ADDRESS <i>814 Annetta Ave Balto 79. Md</i>			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				20. CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <i>Cerebral thrombosis</i>			
21. ANTECEDENT CAUSES				(B) <i>Hypertensive</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <i>Arterio-sclerotic disease</i>			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				23. INTERVAL BETWEEN ONSET AND DEATH			
<i>Inactive Pulm. TB</i>				<i>1 yr</i>			
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No)		27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>0</i>		<i>no</i>		<i>no</i>		<i>yes</i>	
28. I certify that (I) (this hospital) attended the deceased from <i>July 27 19 65</i> to <i>11-5 19 65</i> .		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		31. HOW DID INJURY OCCUR?	
32. I certify that (I) (we) last saw the deceased alive on <i>Sept 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		33. DATE OF INJURY (Month) (Day) (Year) (Hour)		34. INJURY OCCURRED		35. HOW DID INJURY OCCUR?	
36. SIGNATURE <i>W. H. Wong</i>		37. PHYSICIAN'S NAME (Type) <i>WYMAN H. WONG</i>		38. ADDRESS <i>6801 Belair Rd.</i>		39. DATE SIGNED <i>11/6/65</i>	
40. BURNAL CREMATION (Specify)		41. DATE		42. NAME OF CEMETERY or CREMATORY		43. LOCATION (City, town, or county) (State)	
<i>Burnal</i>		<i>11-9-65</i>		<i>Balto National</i>		<i>Balto Md.</i>	
44. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>		45. NAME OF REGISTRAR <i>Robert E. Fisher</i>		46. FUNERAL DIRECTOR <i>John J. Conner</i>		47. ADDRESS <i>Balto, Md.</i>	



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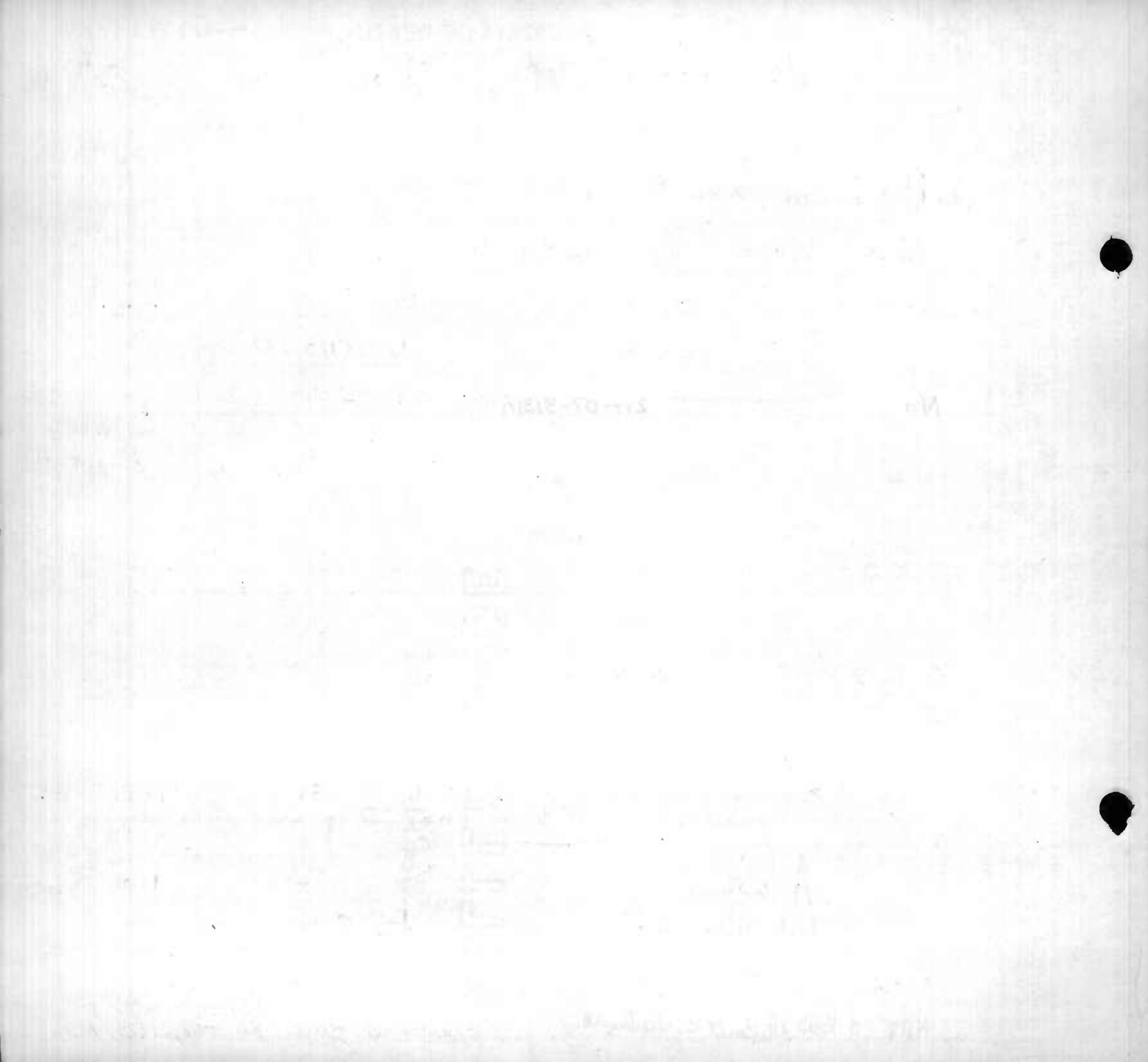
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11376</b>	
BIRTH NO. <b>65 11376</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>GERBEN, Blanche Evelyn</b>		2. DATE AND HOUR OF DEATH <b>November 4, 1965 11:55pm M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <b>St. Josephs Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>A.A. County</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Glen Burnie 52-00</b> D. STREET ADDRESS (If rural, give location) <b>118 Shelly Rd.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Josephs Hospital</b>					
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>11/29/15</b>	9. AGE (in years last birthday) <b>49 yrs</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edward Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Annie S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Roland A. H Gerben 118 Shelly Rd.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Carcinoma of colon with widespread metastases</b> (B) <b>Acute appendiceal abscess</b> (C) <b>Due to</b>		INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 1, 1965</b> to <b>November 4, 1965</b> , that (I) (we) last saw the deceased alive on <b>November 4, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D.R. Govinda</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>November 5, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>D.R. Govinda,</b>		23D. ADDRESS M.D. <b>1400 N. Caroline St., Baltimore, Md. 21213</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>11/8/65</b>	24C. NAME of CEMETERY or CREMATORY <b>LOUDON PARK CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fawcett</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HOWARD H. HUBBARD 4107 WILKENS AVE. 21229</b>	



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BIRTH NO. 65 11377		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11377	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Mr. Luca, Vasile (VASILE LUCA)		NOV 3, 1965		8:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Baltimore City Hospitals		A. STATE Maryland B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL 53-00			
		D. STREET ADDRESS (If rural, give location) 7810 Eastdale Road		21224	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 10.25.84	9. AGE (In years lost birthday) 81	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CARPENTER		11. BIRTHPLACE (State or foreign country) Rumania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LUCA		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 294-07-3131A		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Carcinoma of Rectum		INTERVAL BETWEEN ONSET AND DEATH 8 months	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 09:23.65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF RECTUM		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from 10.11.1965 to 11.3.1965, that (X) (we) lost saw the deceased alive on 11.3.1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE A. Mathur		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED NOV 3, 65	
23C. PHYSICIAN'S NAME (Type) MATHUR A-P.		23D. ADDRESS B.C.H.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-5-65		24C. NAME OF CEMETERY or CREMATORY BELAIR MEMORIAL GARDENS	
24D. LOCATION (City, town, or county) BALTO., MD.		24E. DATE REC'D BY HEALTH DEPT. NOV 8 1965		24F. NAME OF REGISTRAR Robert E. Fisher, MD	
24G. FUNERAL DIRECTOR Charles S. Zeller		24H. ADDRESS 6224 EASTERN AVE. BALTO., MD.			

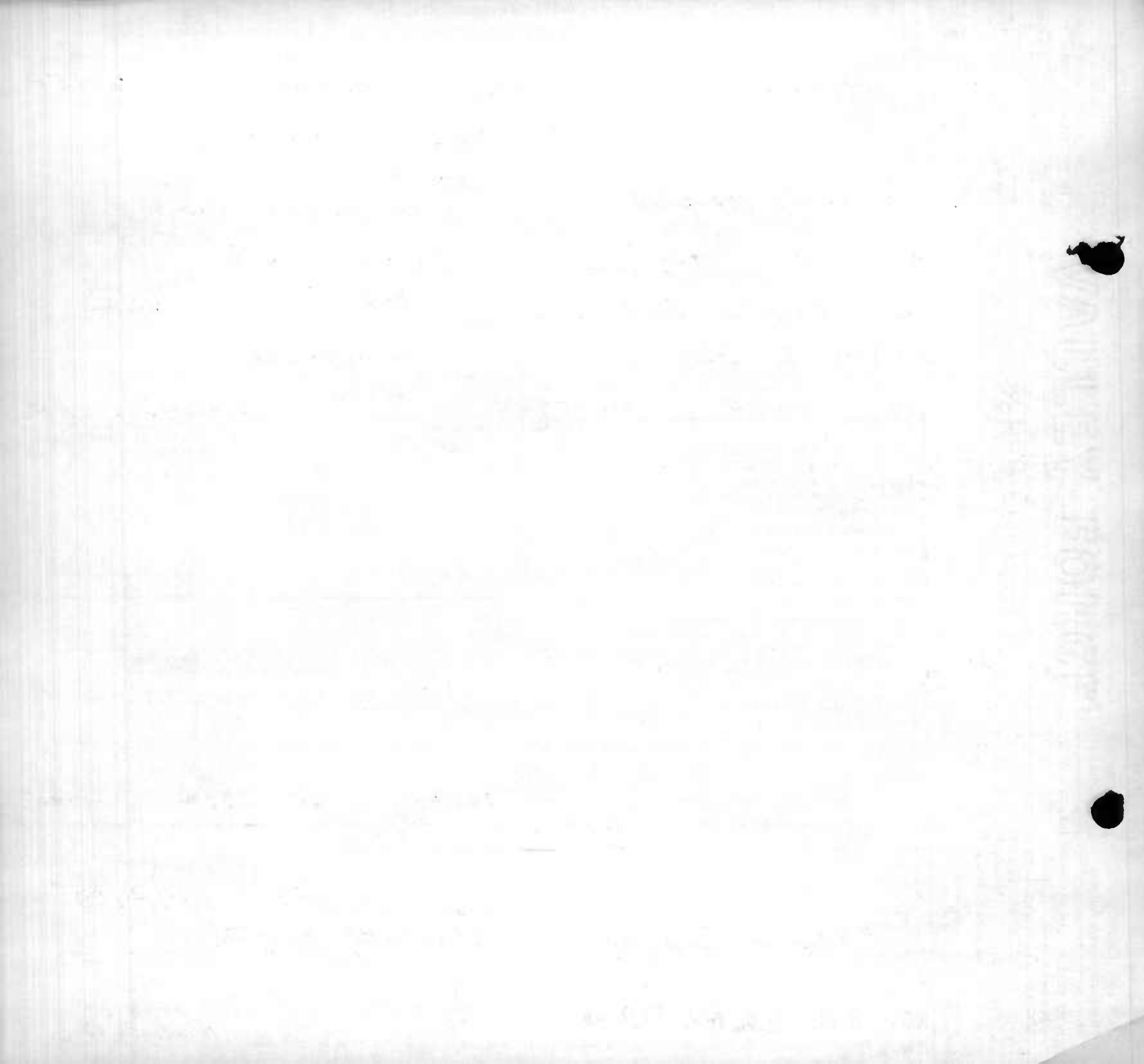




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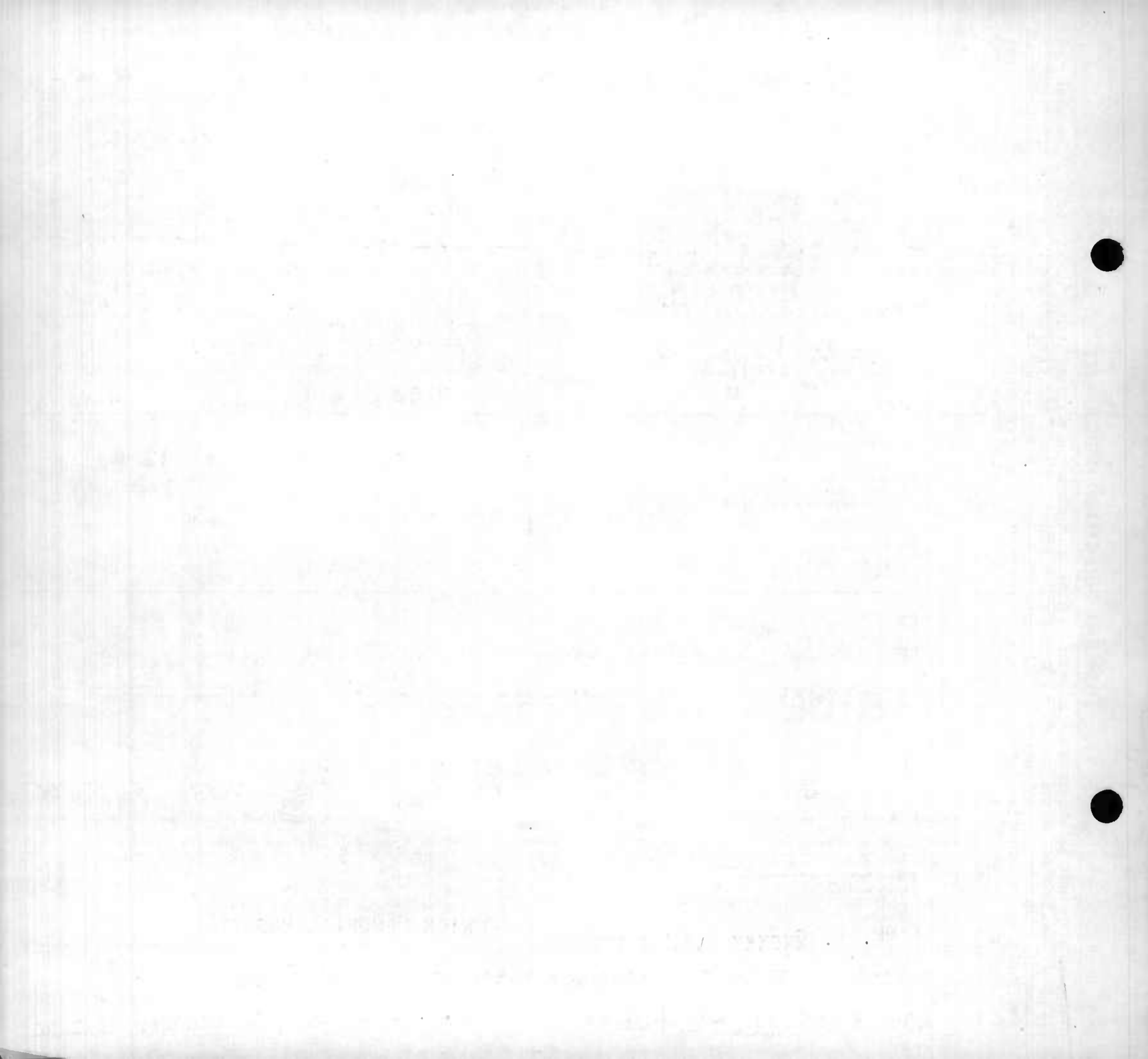
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11378	
BIRTH NO. 65 11378		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Howard Webster Gorsuch</i>		2. DATE AND HOUR OF DEATH <i>11/2/65 6:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>38 University Hospital</i>		A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto</i>	
		D. STREET ADDRESS (If rural, give location) <i>2103 Wilkens Ave.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>10/6/09</i>	9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine Operator</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Electronics</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Brenten L. Gorsuch</i>		14. MOTHER'S MAIDEN NAME <i>Laura Myers</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No NONE</i>		16. SOCIAL SECURITY NO. <i>218 05 9654</i>		17. INFORMANT <i>Wife</i> ADDRESS <i>2103 Wilkens Ave</i>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO <i>Hepatic Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 d.</i>	
II. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO <i>Liver's Cirrhosis</i>		<i>1959</i>	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Bronchopneumonia</i>					
19A. DATE OF OPERATION <i>3/10/20</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholecystitis</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/24 1965</i> to <i>11/2 1965</i> , that (I) (we) last saw the deceased alive on <i>11/2 1965</i> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <i>Philip A. Insley Jr.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/2/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Philip A. Insley</i>		M.D. <i>University Hospital</i>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-6-65</i>		24C. NAME of CEMETERY or CREMATORY <i>MT. PLEASANT</i>	
24D. LOCATION (City, town, or county) <i>Gamber, MD</i>		24E. STATE (State) <i>MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, MD</i>		25C. FUNERAL DIRECTOR <i>Geo. L. Schwab Funeral Home</i> ADDRESS <i>Francis R. Miller 2101 Frederick Ave.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 11379		CERTIFICATE OF DEATH				Registered No. 65 11379			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>DAGMAR E. BALLARD</b>				2. DATE AND HOUR OF DEATH <b>Nov. 4, 1965 9:15 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balt</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 63-00</b>			
D. STREET ADDRESS (If rural, give location) <b>8648 OAKLEIGH RD</b>									
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>4/21/95</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARTIN PAULSEN</b>				14. MOTHER'S MAIDEN NAME <b>AVALONIA MARSH</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>UNK.</b>		17. INFORMANT <b>MARLIN BALLARD</b>		ADDRESS <b>SAME</b>	
18. <b>331X1</b> CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL VASCULAR ACCIDENT</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 HRS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSIVE ARTERIOSCLEROTIC VASCULARS</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that <del>(the)</del> (this hospital) attended the deceased from <b>Nov. 3</b> 19 <b>65</b> to <b>Nov. 4</b> 19 <b>65</b> , that <del>(we)</del> (we) lost saw the deceased alive on <b>Nov. 4</b> 19 <b>65</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (We) (did) <del>(did not)</del> view the body after death.									
23A. SIGNATURE <b>L. Evan Custer</b>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Nov. 4, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. L. CUSTER EVAN CUSTER</b>				23D. ADDRESS M.D. <b>UNION MEMORIAL HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/8/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>			25C. FUNERAL DIRECTOR ADDRESS <b>J.T. Stansbury 6411 Windsor Mill Rd</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11380				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11380	
1. NAME OF DECEASED (Type or Print) <b>GERTRUDE ANNA BRYL</b>				2. DATE AND HOUR OF DEATH <b>10 31 65</b>   <b>1:15P</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 25</b> D. STREET ADDRESS (If rural, give location) <b>5713 Phillips St.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>10 26 01</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CZECHOSLAVAKIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>----- Korecka</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>ST AGNES HOSP RECORDS</b>		ADDRESS	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary &amp; myocardial Infarction</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>10 31 65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10 31 65</b> to <b>10 31 65</b> , that (I) (we) last saw the deceased alive on <b>10 31 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carl H Matthey</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-31-1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARL H MATTHEY</b>				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-4-1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy., A.A. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce, 4001 Ritchie Hwy. Baltimore 25, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 11381		65 11381	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
KOTHA, JOHN A.			11-4-65		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
ST. AGNES HOSPITAL			MARYLAND BALTIMORE		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE ZONE 28		
			D. STREET ADDRESS (If rural, give location)		
			14 S. BEAUMONT AVENUE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	MARRIED	2-5-98	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SALESMAN		217-16-7830		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
PETER KOTHA			MARGARET — ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				ST. AGNES RECORDS-CATON & WILKENS AVES.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 31 19 65 to NOVEMBER 4 19 65, that (I) (we) last saw the deceased alive on NOVEMBER 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Ralphael Marin, MD			11/9/65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
RALPHEAL MARIN, MD			ST. AGNES HOSPITAL - CATON & WILKENS AVE		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11/6/65		LOUDON PARK	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 8 1965		Robert E. Farley, MD		E.S. MACNABB	
				301 FREDERICK RD 21228	



NOV 11 1964

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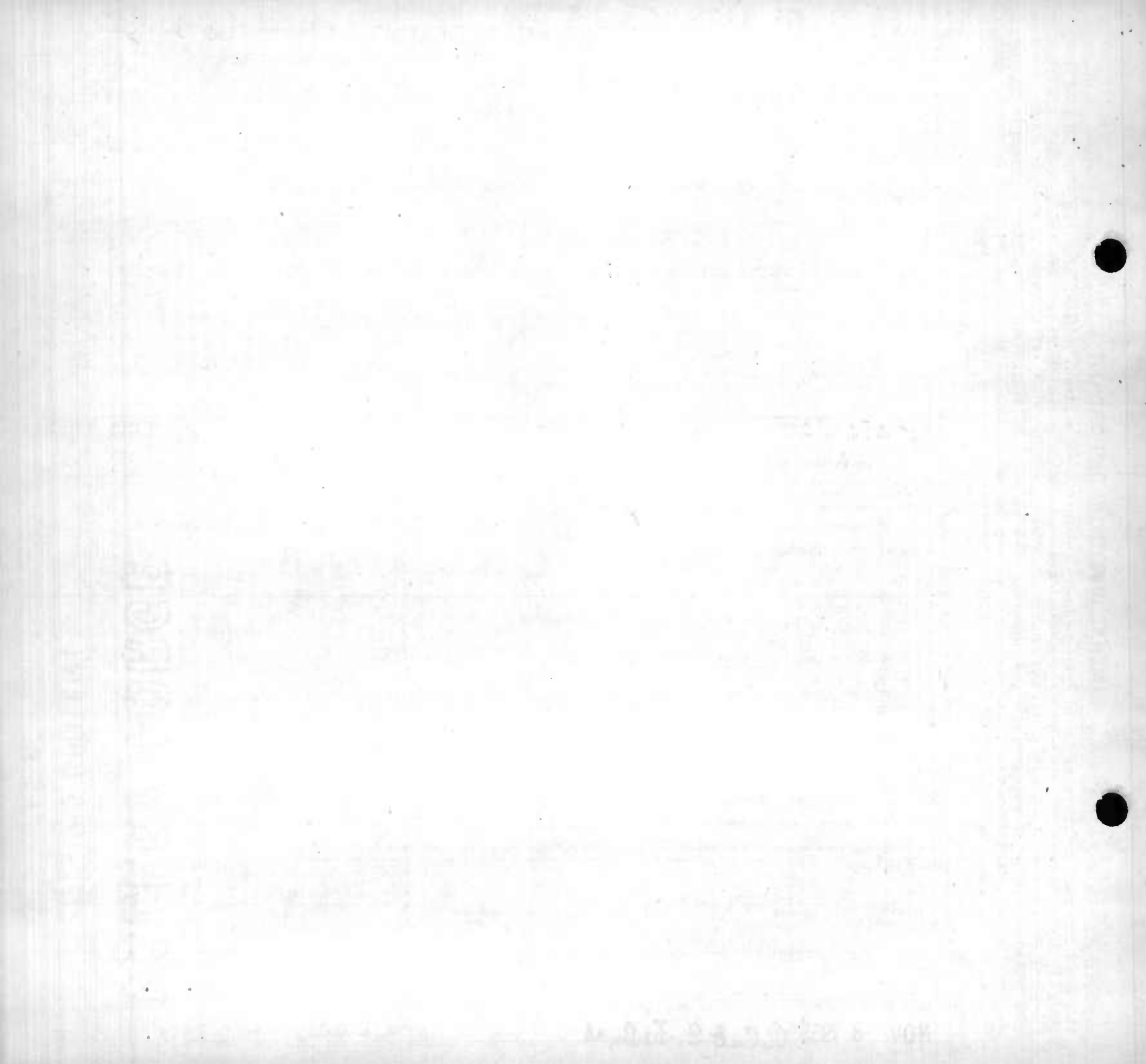
NOV 11 1964

NOV 11 1964

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11382	
BIRTH NO. 65-27145 65 11382		M.E. CASE NO.		1. NAME OF DECEASED	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
MARTIN MARKELL		11-5-65 16:45 a.m.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	
38 UNIV. Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX	
Maryland		A. STATE B. COUNTY		M W	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Baltimore		218 S. Castle St.		8. DATE OF BIRTH	
11-1-65		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		10B. KIND OF BUSINESS OR INDUSTRY	
Balt		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
John Markell		Katherine Ann Sayle		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
Family		Same		(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11-3-65		Tracheo-Esophageal Fistula		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11-3-1965 to 11-5-1965, that (1) (we) last saw the deceased alive on 11-5-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
W. J. Durigan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		11-5-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
		M.D.		Burial	
24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
11 5 1965		New Cathedral		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 8 1965		Robert E. Felsky, MD		Mc Cully 130 E. Fort Av	



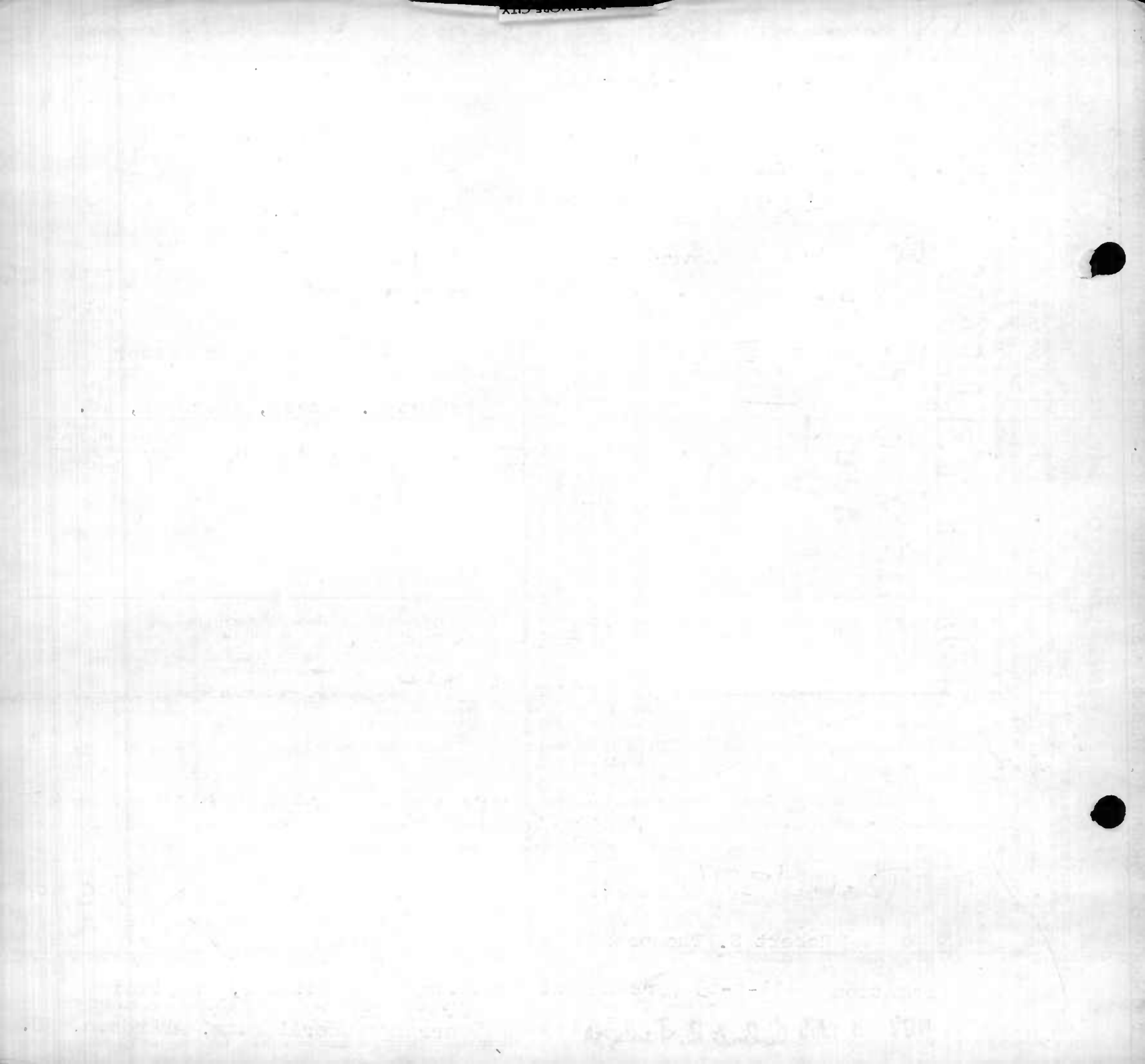
The body of Thomas R. Wasson was released non-med to The Johns Hopkins Hospital

11-4-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

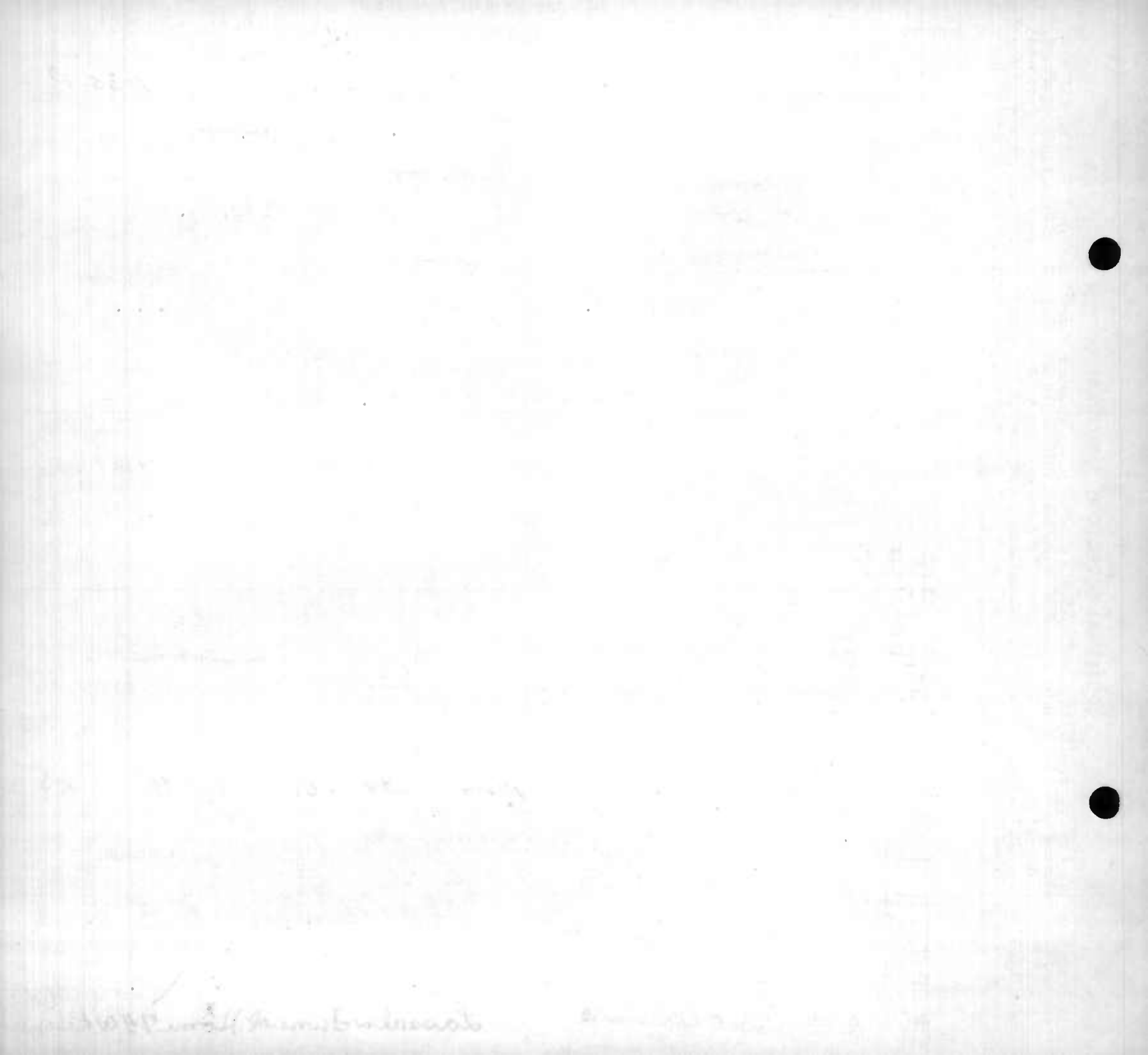
BIRTH NO. <i>Record unknown</i> 65 11383		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11383	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>THOMAS R. WASSON</i>			2. DATE AND HOUR OF DEATH <i>11/5/65 1 9 AM M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <i>pronounced DOA JOHNS HOPKINS</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Harpard</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>ABERDEEN 62-28</i> D. STREET ADDRESS (If rural, give location) <i>479 Roberts way</i>		
5. SEX <i>Male</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>never NEVER</i>	8. DATE OF BIRTH <i>1963 6/2</i>	9. AGE (In years last birthday) <i>2</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Robert E Wasson</i>			14. MOTHER'S MAIDEN NAME <i>XXXXXXXXXX Joyce Brewer</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT ADDRESS <i>Robert E. Wasson, Aberdeen, Md.</i>		
18. <i>180X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Embryonal CH</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Respiratory</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>yes</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April</i> 19 <i>65</i> to <i>Nov</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Nov 3</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert S. Thompson</i>				23B. DATE SIGNED <i>NOV 5, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert S. Thompson</i>		23D. ADDRESS <i>609 N. CAROLINE ST BALT, MD 21205</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>	24B. DATE <i>11-8-65</i>	24C. NAME OF CEMETERY or CREMATORY <i>Greenmount Crematory</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Tarring Funeral Home</i> ADDRESS <i>Aberdeen, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
65 11384					65 11384					
BIRTH NO.					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No.					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
William Woodward					11-4-1965 1:35 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  Gould Convalesarium 6116 Belair Road #6					A. STATE Md.					
					B. COUNTY Baltimore					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 19 Bonnie Avenue Belair, Md.					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12-25-1876	9. AGE (In years last birthday) 88	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Buisness		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Woodward					14. MOTHER'S MAIDEN NAME Emma Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 216-32-9993		17. INFORMANT Mr Arthur H. Woodward 19 Bonnie Aven			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Generalized arteriosclerosis (B) senility (C)				INTERVAL BETWEEN ONSET AND DEATH years years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from MAY 29 1965 to 11-4 1965, that (I) (we) last saw the deceased alive on 11-4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE W.K. WOXE M.D.					23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
W.K. WOXE M.D.					6801 Belair Rd #6 Md					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY			24D. LOCATION (City, town, or county) (State)			
Burial		11-6-65		Moreland Memorial Cemetery			Baltimore Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS					
NOV 8 1965		Robert E. Fisher, MA			Lassahn Funeral Home 7401 Belair Rd (36)					

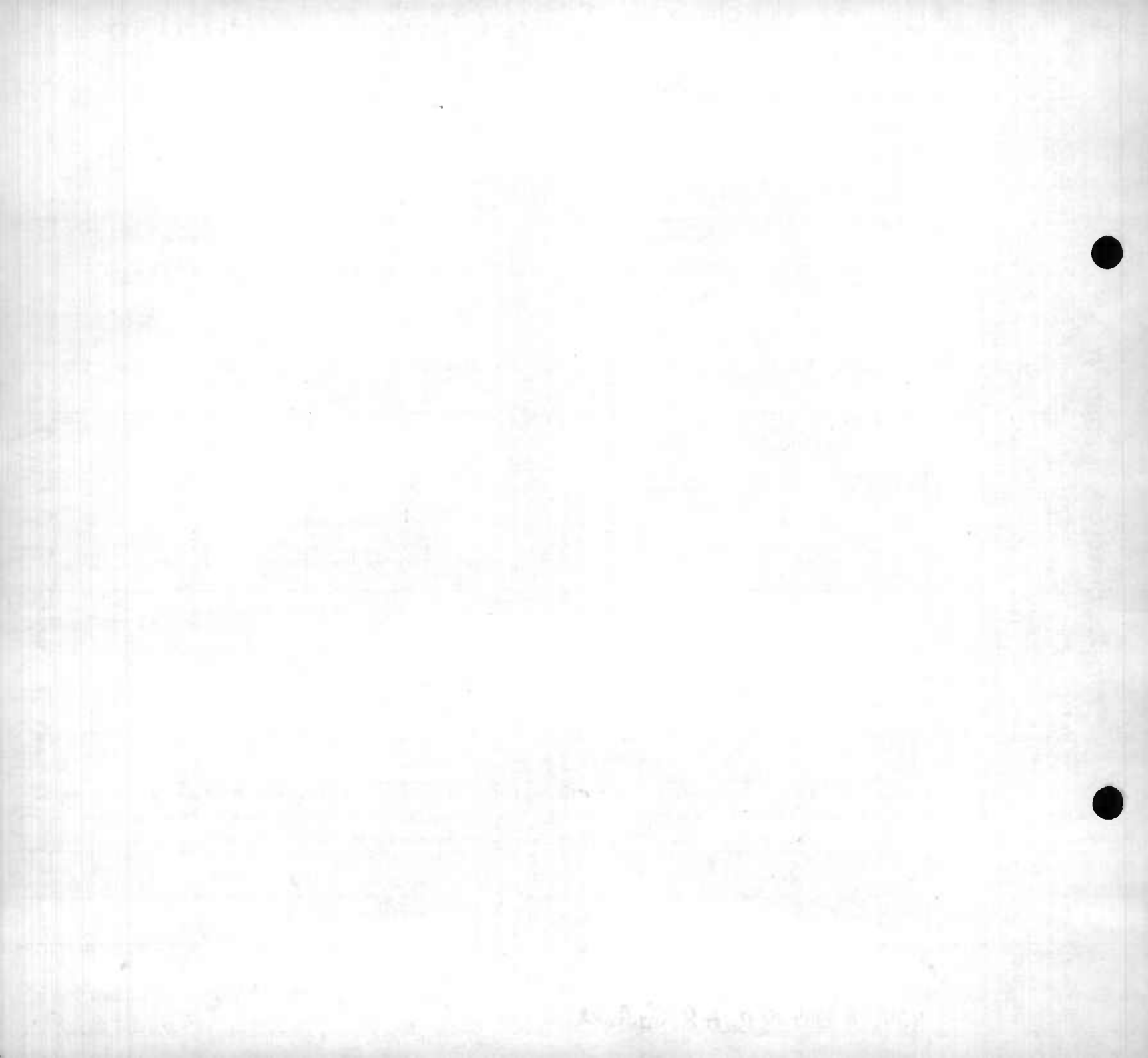




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

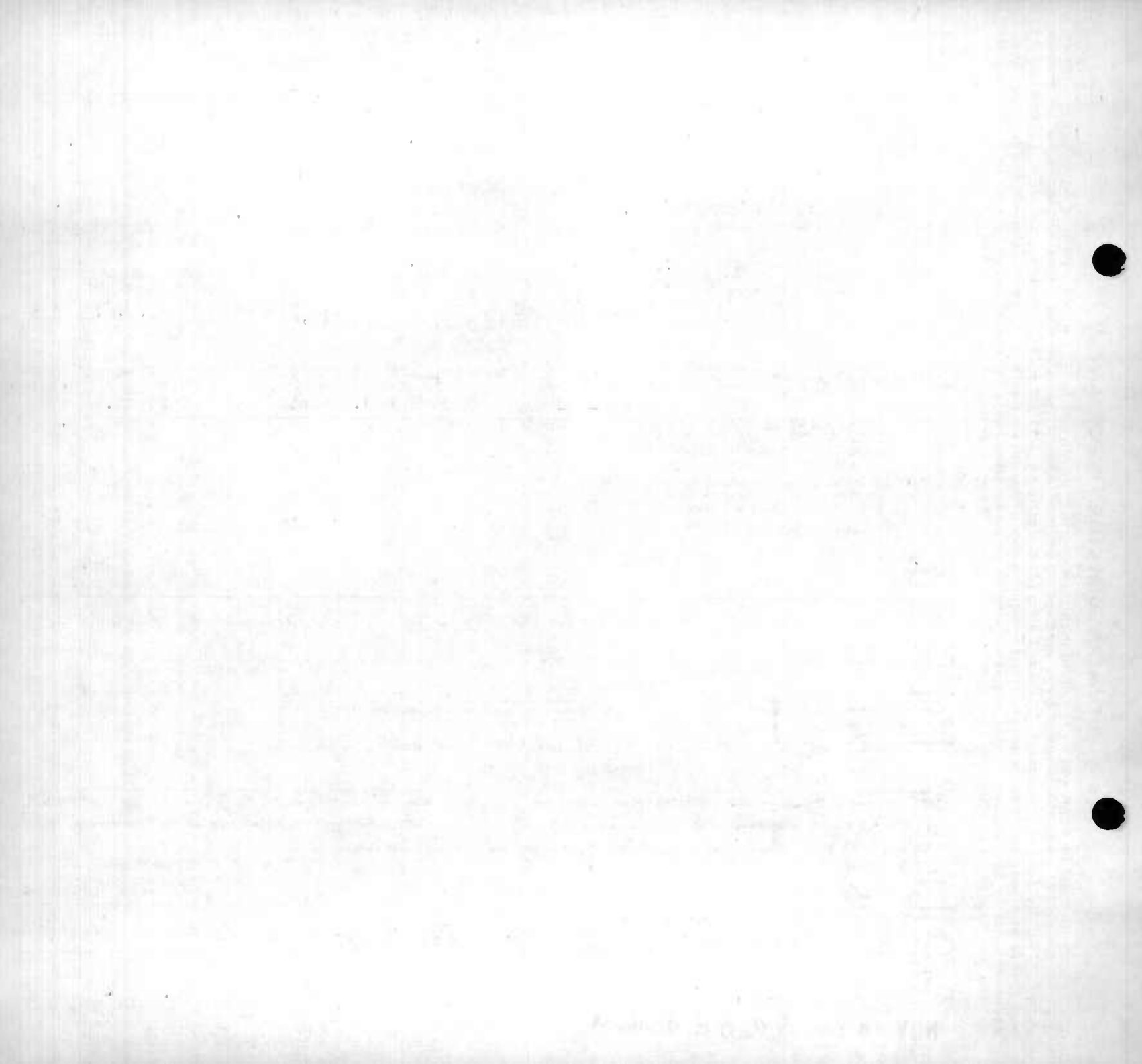
BIRTH NO. 65 11385				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11385	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Hitchcock, Carroll E.</i>		2. DATE AND HOUR OF DEATH <i>10-31-65 15<sup>20</sup> A M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 SINAI HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Pikesville, Maryland 3300</i> D. STREET ADDRESS (If rural, give location) <i>Box 287 Reisterstown Road</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>5/25/66</i>		9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>country club</i>		11. BIRTHPLACE (State or foreign country) <i>Balto.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>?</i>			14. MOTHER'S MAIDEN NAME <i>?</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>?</i>			16. SOCIAL SECURITY NO. <i>216-01-0286</i>		17. INFORMANT <i>Harry Waken MD</i> ADDRESS <i>5356 Carriage Ct Baltimore Md</i>				
18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO (B) <i>Shock</i> DUE TO (C) <i>Hypoglycemia (Diabetic)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>None</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>10-2-1965</i> to <i>10-31-1965</i> , that (I) (we) last saw the deceased alive on <i>10-31-1965</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Harry M. Waken</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <i>10-31-65</i>			
23C. PHYSICIAN'S NAME (Type) <i>Harry M. Waken</i>			23D. ADDRESS <i>5356 Carriage Ct, Baltimore, Md</i>						
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <i>Burial November 3, 1965</i>			24C. NAME OF CEMETERY or CREMATORY <i>Trinity Ridge Cemetery</i>			24D. LOCATION (City, town or county) (State) <i>Pikesville 8, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>			25C. FUNERAL DIRECTOR <i>Frank H. Newell, Pikesville 8, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11386				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11386	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Leon Dubois</b>			
2. DATE AND HOUR OF DEATH <b>11/3-1965</b> <b>825</b> <b>A M.</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <b>Ardley Nursing Home</b> <b>2095 Rockrose Ave.</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1/3-06</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>843 Powers St.</b>				5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>			
8. DATE OF BIRTH <b>Apr. 17, 1889</b> 9. AGE (in years last birthday) <b>76</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>			
11. BIRTHPLACE (State or foreign country) <b>Paris, France</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Isador Dubois</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-10-5099</b>			
17. INFORMANT <b>Beulah G. Dubois</b>				ADDRESS <b>843 Powers St.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>331X 1260X</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebro-vascular accident</b>				2 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>diabetes mellitus</b>				13 years			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>this hospital</del> attended the deceased from <b>Jan. 22</b> 19 <b>52</b> to <b>Mar. 3</b> 19 <b>65</b> , that (I) <del>he</del> last saw the deceased alive on <b>Nov. 2</b> 19 <b>65</b> and that in <del>my</del> <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>he</del> <del>she</del> (did not) view the body after death.							
23A. SIGNATURE <b>Reuben Hoffman</b>				23B. DATE SIGNED <b>11-5-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Reuben Hoffman</b>				23D. ADDRESS <b>846 W. 36th St., Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>11/5, 1965</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Hebrew Friendship Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>			
25C. FUNERAL DIRECTOR <b>Frank H. Leitz</b>				ADDRESS <b>814 W 36th St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">65 11387</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 1.5em;">65 11387</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Francis Earl Morgan</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">November 4, 1965 11<sup>10</sup> AM</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1306</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Union Memorial Hospital</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">853 W. 34<sup>th</sup> Street</span>			
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6-13-81</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">84 yrs</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Foreman</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Chemical Co</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">N. Va.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Winfield Morgan</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Jane</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220-07-3594</span>		17. INFORMANT <span style="font-size: 1.2em;">EARL L. MORGAN</span>	
18. <span style="font-size: 1.2em;">420.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">myocardial infarction</span>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if (this hospital) attended the deceased from <span style="font-size: 1.2em;">Aug 1964</span> 19 to <span style="font-size: 1.2em;">Nov 1965</span> 19 that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10-7</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Francis X. Carnody MD</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">11-4-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">FRANCIS X. CARNODY MD</span>				23D. ADDRESS <span style="font-size: 1.2em;">Union Memorial Hospital</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">11-6-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">MEADOWRIDGE</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Dorsey, Howard Co Md</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">NOV 8 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. FALKNER</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Frank H. Seitz</span>		25D. ADDRESS <span style="font-size: 1.2em;">814 W 36<sup>th</sup> St</span>			

10-10-1910

From -

230-07-2284 BAR. J. M. 1910

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11388		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11388	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Jerome A. Bishop			2. DATE AND HOUR OF DEATH Oct 26, 1965 10:30 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2417 Edmondson Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2417 Edmondson Ave.		
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/4/1898	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10B. KIND OF BUSINESS OR INDUSTRY Gen. Serv. Agency		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
13. FATHER'S NAME Howard Bishop			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 219-01-6728-A			17. INFORMANT Bernice Hasty-3007 Presbury St.		
16. SOCIAL SECURITY NO. 219-01-6728-A			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Respiratory failure Coronary Occlusion Hypertension & arteriosclerotic Cardio-vascular renal disease		
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 1961 19 to 10/26/65 19 that (I) (we) last saw the deceased alive on 10/15/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Shorofsky			23B. DATE SIGNED 10/27/65		
23C. PHYSICIAN'S NAME (Type) S. Shorofsky			23D. ADDRESS 601 N. W. W. St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/29/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem	
24D. LOCATION Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave			



10/2/67

Department of Agriculture  
Bureau of Plant Industry  
Washington, D.C.

10/2/67

10/2/67

10/2/67

Col. H. W. W. W.

10/2/67

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11389				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11389	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MAMIE SLOWE</b>				2. DATE AND HOUR OF DEATH <b>Nov. 6/65 12:30 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>18-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
D. STREET ADDRESS (If rural, give location) <b>947 N. FRANKLIN ST.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>12-26-91</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State foreign country) <b>Talbot Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Alexander Russell</b>				14. MOTHER'S MAIDEN NAME <b>Ella Jackson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Inez Butler - 705 Wilbur Av.</b>	
18. <b>332X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRO-VASCULAR ACCIDENT</b> DUE TO <b>BASILAR ARTERY THROMBOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Parkinson's 2° to #1</b>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> 19 <b>65</b> to <b>Nov. 6</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Nov. 6</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Rolando M. Sabundayo</b> M.D.				23B. DATE SIGNED <b>11-6-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>ROLANDO M. SABUNDAYO</b> M.D.				23D. ADDRESS <b>UNIVERSITY HOSPITAL &amp; MARYLAND GEN. HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/10/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Archbuteus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Herbert E. Smith</b>		ADDRESS <b>3035 W. North Ave.</b>	



1

65 11390

BALTIMORE CITY HEALTH DEPARTMENT

65 11390

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER

TABB

2. DATE AND HOUR PRONOUNCED DEAD

November 3, 1965 10:15 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2812 Belmont Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct. 6, 1889

9. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Sanitation Dept.

11. BIRTHPLACE (State or foreign country)

Gloucester Co. Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willis Tabb

14. MOTHER'S MAIDEN NAME

Charlotte Patterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

213-09-7204

17. INFORMANT

ADDRESS

Lillian Toler-2812 Belmont Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/4/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/6/65

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Pk.

23D. LOCATION (City, town, or county) (State)

Baltimore Co. Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 8 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

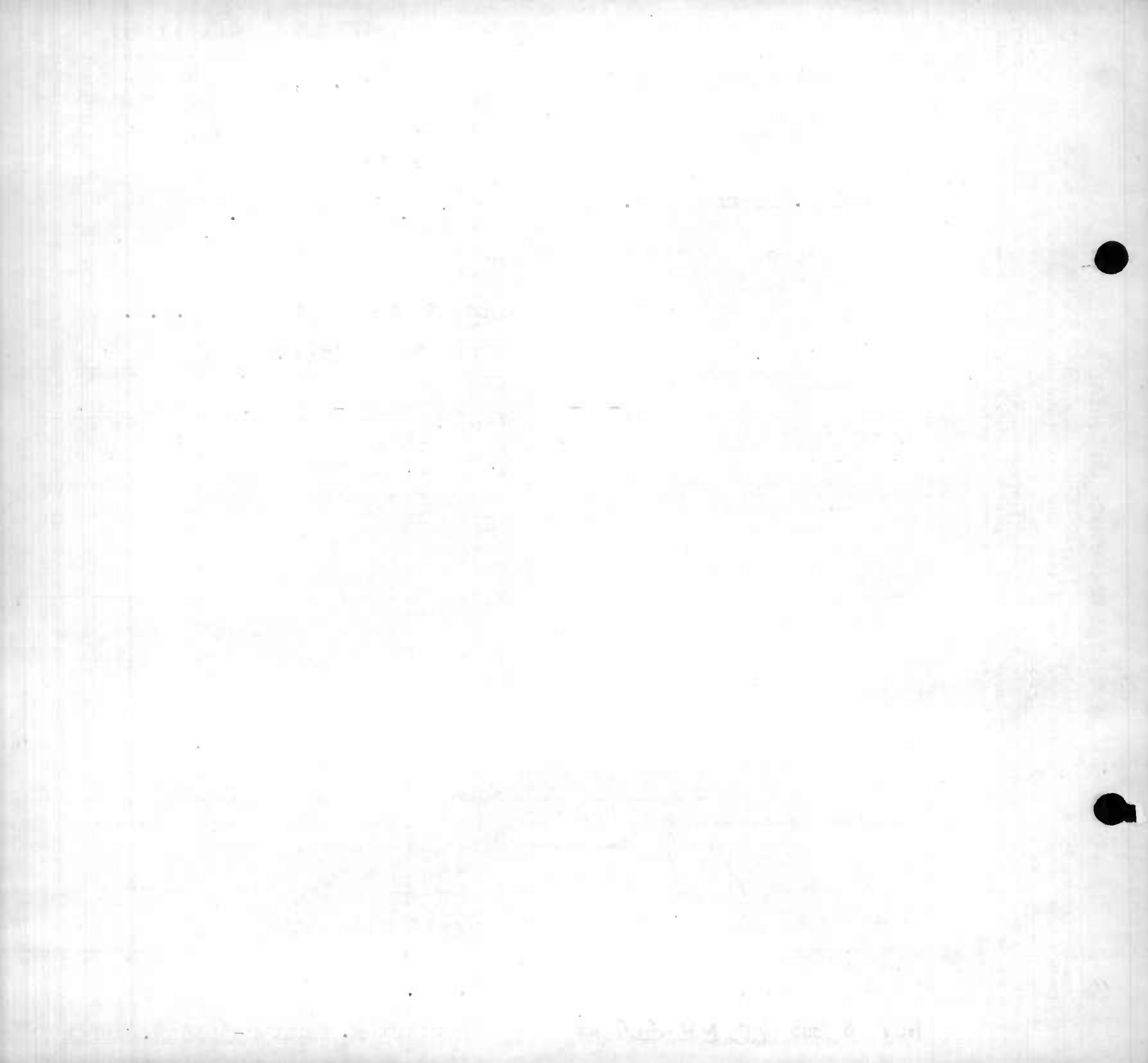
Herbert E. Nutter-3035 W. North Ave

WALLEN BOICE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11391	
BIRTH NO. 65 11391		CERTIFICATE OF DEATH		Registered No. 65 11391	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Rosa Rebecca Bivins		2. DATE AND HOUR OF DEATH Nov. 1, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 77-03			
FULL NAME OF HOSPITAL OR INSTITUTION 841 N. Fremont Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 841 N. Fremont Ave.			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June 24, 1886	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Estridge Adams		14. MOTHER'S MAIDEN NAME Jennie Maitland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-32-8852		17. INFORMANT Edna Holley-2410 W. Lanvale St.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Arterio sclerosis Cardiovascular disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 16 1965 to Nov 1 1965, that (I) (we) last saw the deceased alive on Oct 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Royston B. Scott		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov 2, 65	
23C. PHYSICIAN'S NAME (Type) ROYSTON B. SCOTT		23D. ADDRESS 18014 Baltimore St			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/65		24C. NAME of CEMETERY or CREMATORY Loudon Park Natl. Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave	





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11392		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65 11392	
1. NAME OF DECEASED (Type or Print) <b>BILLY JOE BROWN</b>			2. DATE AND HOUR OF DEATH <b>NOV. 7, 1965 8:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>TENN.</b> B. COUNTY <b>V-39</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>U.S. PUBLIC HEALTH SERVICE HOSPITAL WYMAN PK. DRIVE &amp; 31st ST.</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>PITTSBURG</b>		
D. STREET ADDRESS (If rural, give location) <b>106 E. 8th St</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>NOV. 2, 1939</b>	9. AGE (In years last birthday) <b>32</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AMERICAN SEAMAN</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>SEAFARER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JAMES WILLIAM BROWN</b>			14. MOTHER'S MAIDEN NAME <b>JANIE RAE DOBBINS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>411 48 2221</b>		
17. INFORMANT <b>RECORDS NC PHS HOSPITAL BALTO, MD.</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>SEPSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>BILATERAL STAGHORN 8 YEARS CALCULI</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>11-3-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RENAL CALCULI</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 18 1965</b> to <b>NOV. 7 1965</b> , that (I) (we) lost saw the deceased alive on <b>NOV. 7 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Carl Siegrist SAS</b> M.D.				23B. DATE SIGNED <b>NOV. 7, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARL SIEGRIST SAS</b> M.D.				23D. ADDRESS <b>US PHS HOSPITAL BALTO, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>11/7/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>E. Pittsburg Tenn.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>William J. Tucker + Sons North + Pa. Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

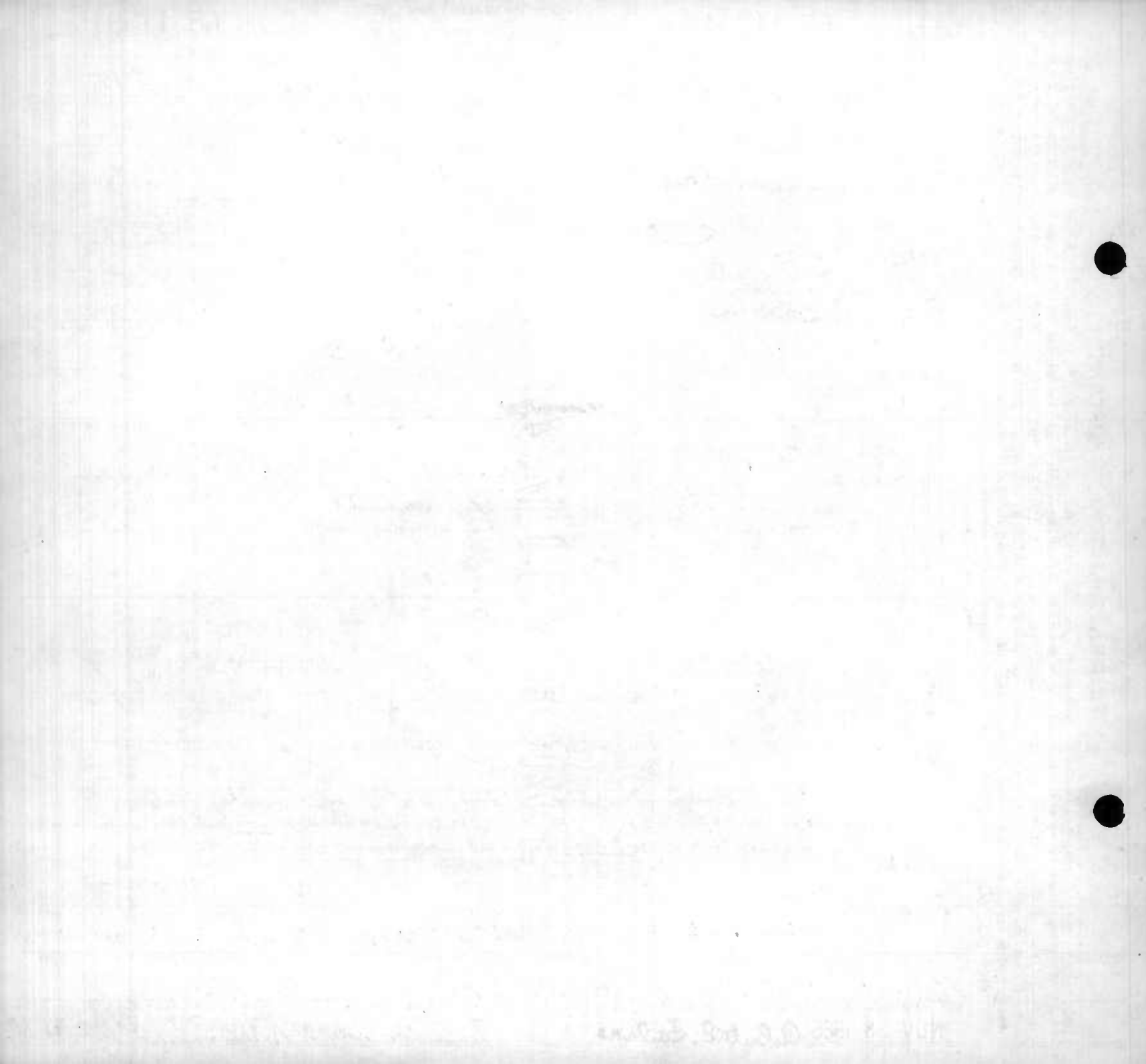
BIRTH NO. 65 11393				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11393	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Annabelle Averette</b>			
2. DATE AND HOUR OF DEATH <b>11-3-65 at 10:10 PM</b>				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				A. STATE <b>Maryland</b> B. COUNTY <b>12-04</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				D. STREET ADDRESS (If rural, give location) <b>2013 North Calvert Street 21218</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>Single</b>	8. DATE OF BIRTH <b>3-8-28</b>	9. AGE (in years lost birthday) <b>37</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Averette</b>				14. MOTHER'S MAIDEN NAME <b>Juel Locklear</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>21224</b>		ADDRESS <b>Records: BCH-4940 Eastern Avenue</b>	
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Cardiorespiratory Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma of the Breast</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Innapropriate ADH Secretion</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>2-3 years</b>							
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2 none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>no</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-18-65</b> to <b>11-3-65</b> , that (I) (we) first saw the deceased alive on <b>11-3-65 at 10:10 PM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Steve L. Johnson</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-3-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Steve L. Johnson</b>				23D. ADDRESS <b>1620 McElderry St., Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/8/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm C March 928 E. North Ave. Balto., Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11394</b>	
BIRTH NO. <b>65 11394</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Goulon, Bizzie</b>		2. DATE AND HOUR OF DEATH <b>11/5/65 6:15 a.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>91 Montebello State Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>482</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>734 W. Fayette St. apt. 703</b>			
5. SEX <b>male</b>	6. RACE <b>negro</b>	7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>8/8/1937</b>	9. AGE (In years last birthday) <b>38</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fish Market Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Willie Goulon</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Blue</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>225-30-1091</b>		17. INFORMATION ADDRESS <b>Hospital Records</b>	
18. <input checked="" type="checkbox"/> <b>002.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>c. Pericarditis</b>		CAUSE OF DEATH (A) <b>Pulmonary Tuberculosis</b> DUE TO <b>c. Pericarditis</b> (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/13/65</b> 19 to <b>11/5/65</b> 19, that (I) (we) last saw the deceased alive on <b>11/5/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Daniel G. Lai</b>				23B. DATE SIGNED <b>11/5/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Daniel G. Lai</b>				23D. ADDRESS M.D. <b>3301 Argonne Drive, Baltimore, Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov 9, 1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Faden</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home 3791 Schroeder St.</b>			



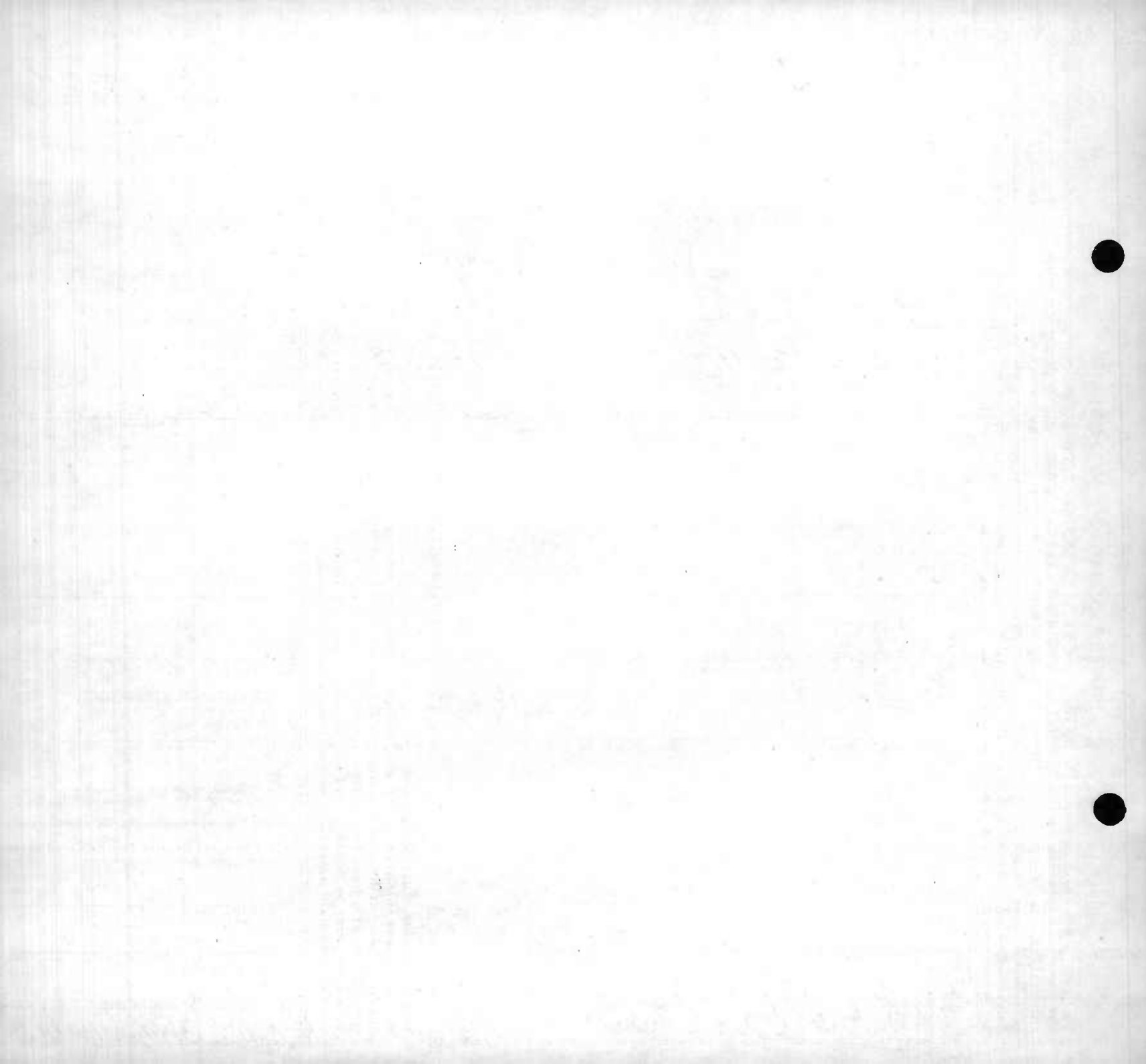


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11395</b>	
65 11395					
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Gross, Olivia</b>	
2. DATE AND HOUR OF DEATH <b>11-4-1965 1230 P.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bella Mac Nursing Home</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>16-05</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b>			
D. STREET ADDRESS (If rural, give location) <b>615 N. Benton St.</b>		5. SEX <b>Female</b> 6. RACE <b>Colored</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>			
8. DATE OF BIRTH <b>July 4/1871</b> 9. AGE (in years last birthday) <b>94</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>LANCASTER Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Louis Ball</b>		14. MOTHER'S MAIDEN NAME <b>Texas ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Evelyn Jenkins</b> ADDRESS <b>615 N. Benton St.</b>	
18. <b>422.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardio Vascular Disease</b>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>arterio sclerosis</b>		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 5 1965</b> to <b>Nov 4 1965</b> that (I) (we) last saw the deceased alive on <b>Nov 4 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Wm R Johnson</b> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11-4-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Wm R Johnson</b> M.D.		23D. ADDRESS <b>403 Med Arts Bldg</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/8/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Catharine Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fadden, MD</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b> ADDRESS <b>3197 Scholten St.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

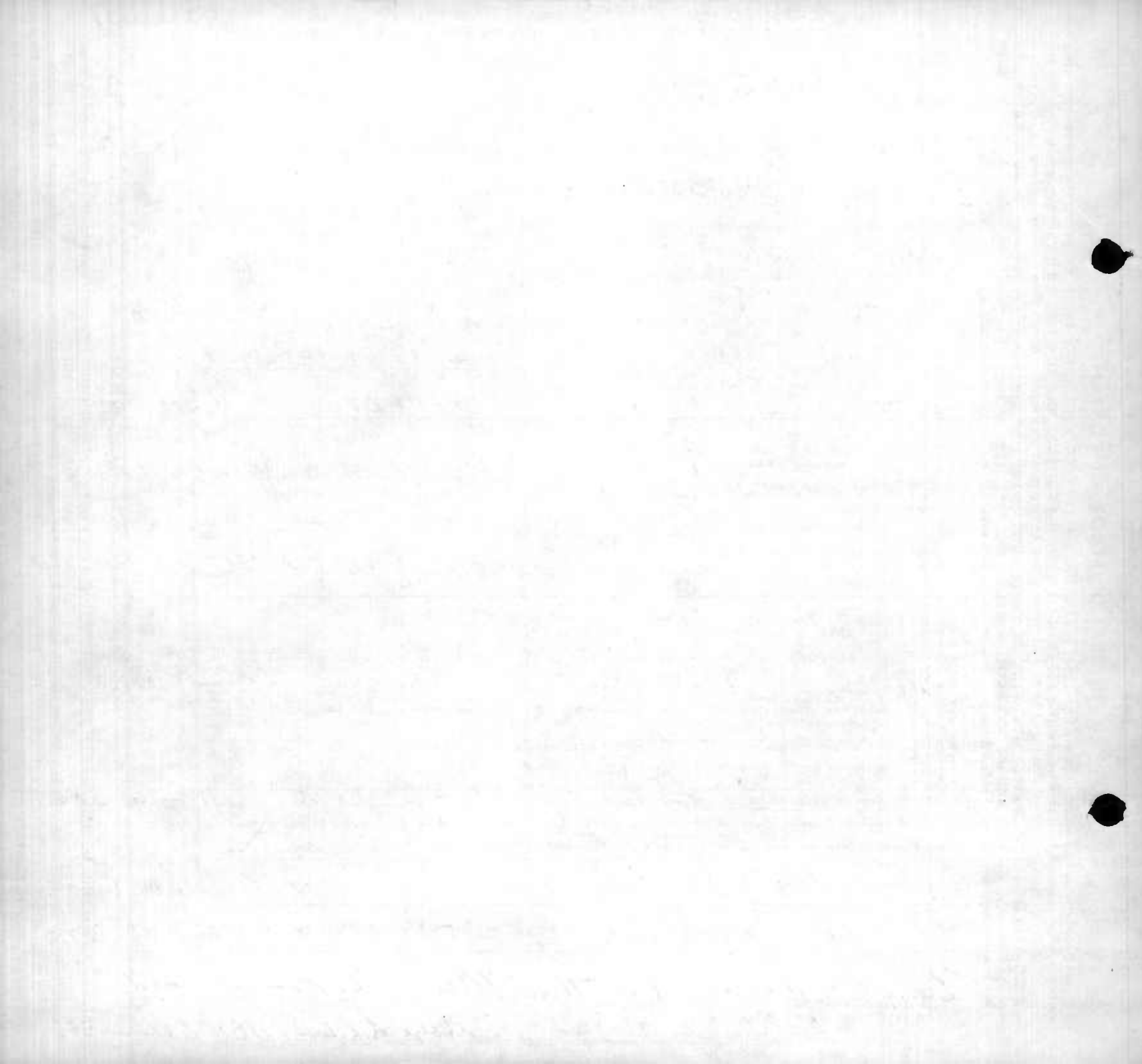
BIRTH NO. 65 11396				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11396	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HARRY ALBERT JOHNSON</b>				2. DATE AND HOUR OF DEATH <b>11-5-65</b>		1 2 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY OF MARYLAND Hosp.</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>18-01</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>857 W. Vine St.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11/21/1917</b>		9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>217-01-4198</b>		17. INFORMANT <b>Mrs Evelyn Jackson</b>		ADDRESS <b>857 W. Vine St.</b>
18. <b>442 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Atherosclerosis &amp; nephrosclerosis</b>				(B) DUE TO			
				(C) <b>Hypertension</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NONE</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>NONE</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NONE</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>19 65</b> to <b>NOVEMBER 5 19 65</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 5 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Timothy Kenney Gray</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-5-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>TIMOTHY KENNEY GRAY M.D.</b>				23D. ADDRESS <b>UNIVERSITY OF MARYLAND Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/10/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Irvin T. Carroll</b> ADDRESS <b>1712 W. North Ave</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

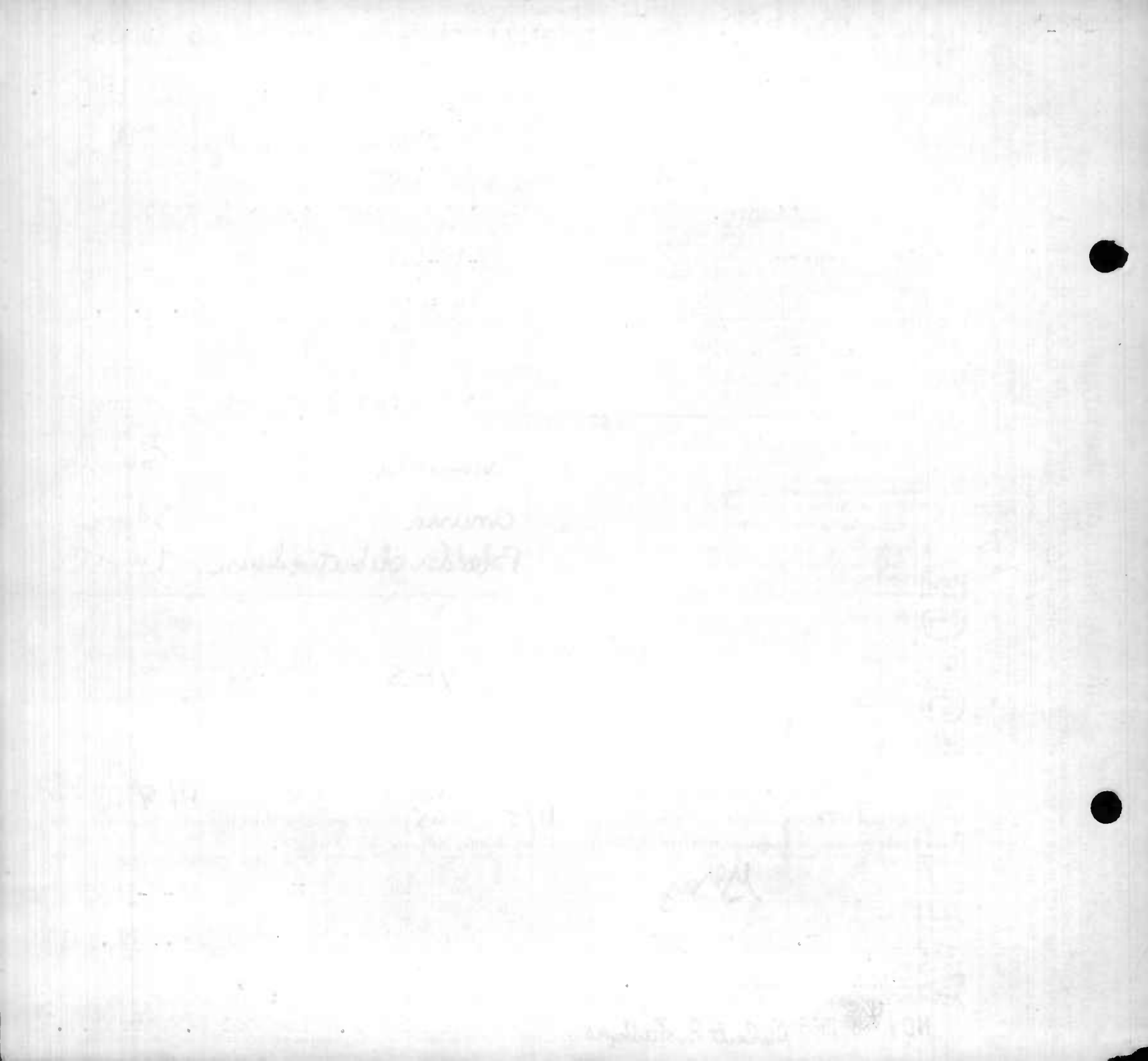
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 11397		CERTIFICATE OF DEATH		65 11397	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>WILLIAM J. BARBER</b>			2. DATE AND HOUR OF DEATH <b>NOV 6, 1965 17 05 P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 MERCY HOSPITAL INC.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE #17</b> D. STREET ADDRESS (If rural, give location) <b>1835 W. NORTH AVE</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>11-8-1890</b>	9. AGE (In years lost birthday) <b>74 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
13. FATHER'S NAME <b>THOMAS BARBER</b>			14. MOTHER'S MAIDEN NAME <b>JOSEPHINE VERMONT</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>PATIENT - AS ABOVE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>181.0 I</b>		CAUSE OF DEATH (A) DUE TO <b>Cardio-respiratory failure</b> (B) DUE TO <b>Cancer metastatic to heart &amp; lungs</b> (C) DUE TO <b>Carcinoma of the bladder</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>? few mos.</b> <b>? few mos.</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3/11/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bladder Ca</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES - BLADDER CA.</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-15</b> 19 <b>65</b> to <b>11-6</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>11-6</b> - 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Emilio P. Gonzalez</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>NOV. 6/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>EMILIO P. GONZALEZ</b>		23D. ADDRESS <b>MERCY HOSP. 301 S. PAUL PLACE, BALTO.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11-10-65</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Catherine Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George A. Kilan 1348 N. Calhoun St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11398				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11398	
1. NAME OF DECEASED (Type or Print) <b>Julius Combs</b>				2. DATE AND HOUR OF DEATH <b>November 5, 1965 11:45 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21-02</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>					
				D. STREET ADDRESS (If rural, give location) <b>1315 Bayard Street 21230</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>5-15-1875</b>		9. AGE (In years last birthday) <b>90</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Julius Combs</b>				14. MOTHER'S MAIDEN NAME <b>Laura</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>					
18. <b>606X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>				CAUSE OF DEATH (A) DUE TO <b>Uremia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Anuria</b>				(B) DUE TO <b>Anuria</b>				<b>3 days</b>	
				(C) <b>Bladder obstructive disease</b>				<b>1 month</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10/7 1965</b> to <b>11/5 1965</b> , that (I) (we) lost saw the deceased alive on <b>11/5 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>George Gey</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-5-1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. George Gey</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Balto., Md. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/10/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles A. Rice 661 W. Barre St.</b>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11399		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11399	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) (WILLIAM JOSHUA LAUER) William J. LAUER		2. DATE AND HOUR OF DEATH 11/5/65 6:25 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital		A. STATE Maryland B. COUNTY 2-02			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 213 S. Register Street 21231			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/5/92	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Retired 8 Years		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Lauer		14. MOTHER'S MAIDEN NAME Lydia Coker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217 01 6790		17. INFORMANT ADDRESS 213 South Register Street Mrs Mabel L. Lauer 21231	
18. 3-27-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Bronchopneumonia (B) Multiple pulmonary infarct (C) Emphysema		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (M) (this hospital) attended the deceased from 11/1/65 19 to 11/5/65 19, that (M) (we) lost saw the deceased alive on 11/5/65 19 and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert R. Holtzhaus		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/6/65	
23C. PHYSICIAN'S NAME (Type) ROBERT R. HOLTZHAUS		23D. ADDRESS M.D. 1213 Light St. 21230			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/65		24C. NAME OF CEMETERY or CREMATORY Gardens Of Faith	
				24D. LOCATION Baltimore Maryland (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Henry Sander & Sons Inc. Baltimore Maryland 21213	

William H. Holtzhaus

11/12/12

Thailand

Baltimore

215 2 Webster Street

11/12/12

11/12

Baltimore

Physis Cakes

South Baltimore General Hospital

11/12/12

Joseph Lauer

Yes

11/12/12

11/12/12

11/12/12

ROBERT R. HOLTZHAUS

215 2 Webster Street

William H. Holtzhaus

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11400		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11400	
M.E. CASE NO. 65 11400		CERTIFICATE OF DEATH		1178410	
1. NAME OF DECEASED (Type or Print) Baby Boy Bowlin		2. DATE AND HOUR OF DEATH 11/5/65 @ 11:00 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		A. STATE Maryland B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 31			
		D. STREET ADDRESS (If rural, give location) 117 N. Duncan St			
5. SEX male	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never	8. DATE OF BIRTH 11/5/65	9. AGE (In years last birthday) Newborn	10. Under 1 Yr. Months Days 0 23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Michael Bowlin		14. MOTHER'S MAIDEN NAME Gloria Giffin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 762.5T DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Asphyxia (B) IMMATURITY (C)		INTERVAL BETWEEN ONSET AND DEATH 23 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>this</del> (this hospital) attended the deceased from 5 November 1965 to 5 November 1965, that (I) <del>was</del> last saw the deceased alive on 5 November 1965 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE Lawrence R. Donahue M.D.				23B. DATE SIGNED 11-5-65	
23C. PHYSICIAN'S NAME (Type) LAWRENCE R. DONAHUE		23D. ADDRESS 601 N. BROADWAY BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 11-5-65		24C. NAME OF CEMETERY OR CREMATORY The Johns Hopkins Hos.	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>505 65 11401</b>		BALTIMORE CITY HEALTH DEPT.		Registered No. <b>65 11401</b>	
M.E. CASE NO.		Sencindiver		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Harry Ward Sencindiver		11-4-1965 4.45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Baltimore		D. STREET ADDRESS (If rural, give location)	
		1426 West Fayette Street		21223	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
Male	White	Widower	1-8-1899	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				West Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles Lewis Sencindiver		Ella Rose Voorhees		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No No				Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
199.21 Ca melanoteres		Ca melanoteres		1 month	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		R L W mass		?	
		Ca		}	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Recurbite		1 month	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		YES	Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 10/14 1965 to 11/4 1965, that (I) (we) last saw the deceased alive on 10/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
G. Gey				11/4/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	11-7-65	Elmwood Cemetery		Shepherdstown, Jefferson, West Va.,	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 8 1965 Robert E. Farber, M.D.				H. K. Brown Brown Funeral Home Martinsburg, W. Va.,	

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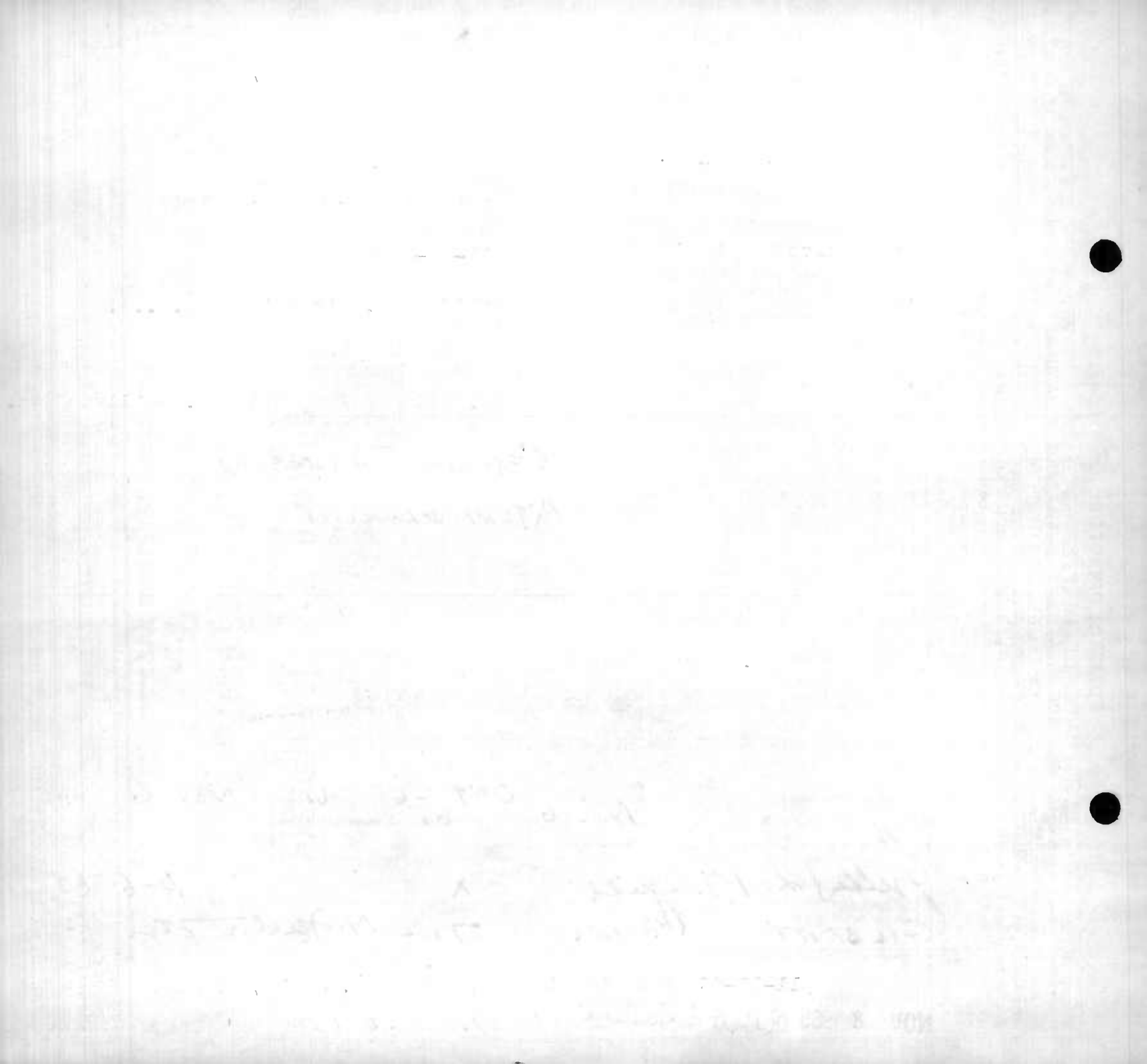
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11402		REGISTERED NO. 65 11402	
1. NAME OF DECEASED (Type or Print) <b>KATIE (KATHERINE) SMITH</b>				2. DATE AND HOUR OF DEATH <b>NOVEMBER 6, 1965</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3018 Windsor Avenue</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-217</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3018 Windsor Avenue 21216</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>11-21-1887</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Halifax Co. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES CROWDER</b>				14. MOTHER'S MAIDEN NAME <b>DELILA CROWDER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MR. ROSCOE SMITH 1716 N. Smallwood St.</b>			
18. <b>332X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL THROMBOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROSIS</b>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 26 1965</b> to <b>NOV 6 1965</b> , that (I) (we) last saw the deceased alive on <b>NOV 6 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>GILBERT L. BANFIELD</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11-6-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>GILBERT L. BANFIELD</b>				23D. ADDRESS <b>722 N. Fulton Ave Balt. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-10-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ZION HILL BAPTIST CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>MAYO, VIRGINIA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT FUN'L HOME</b>		ADDRESS <b>1701 Laurens St</b>	

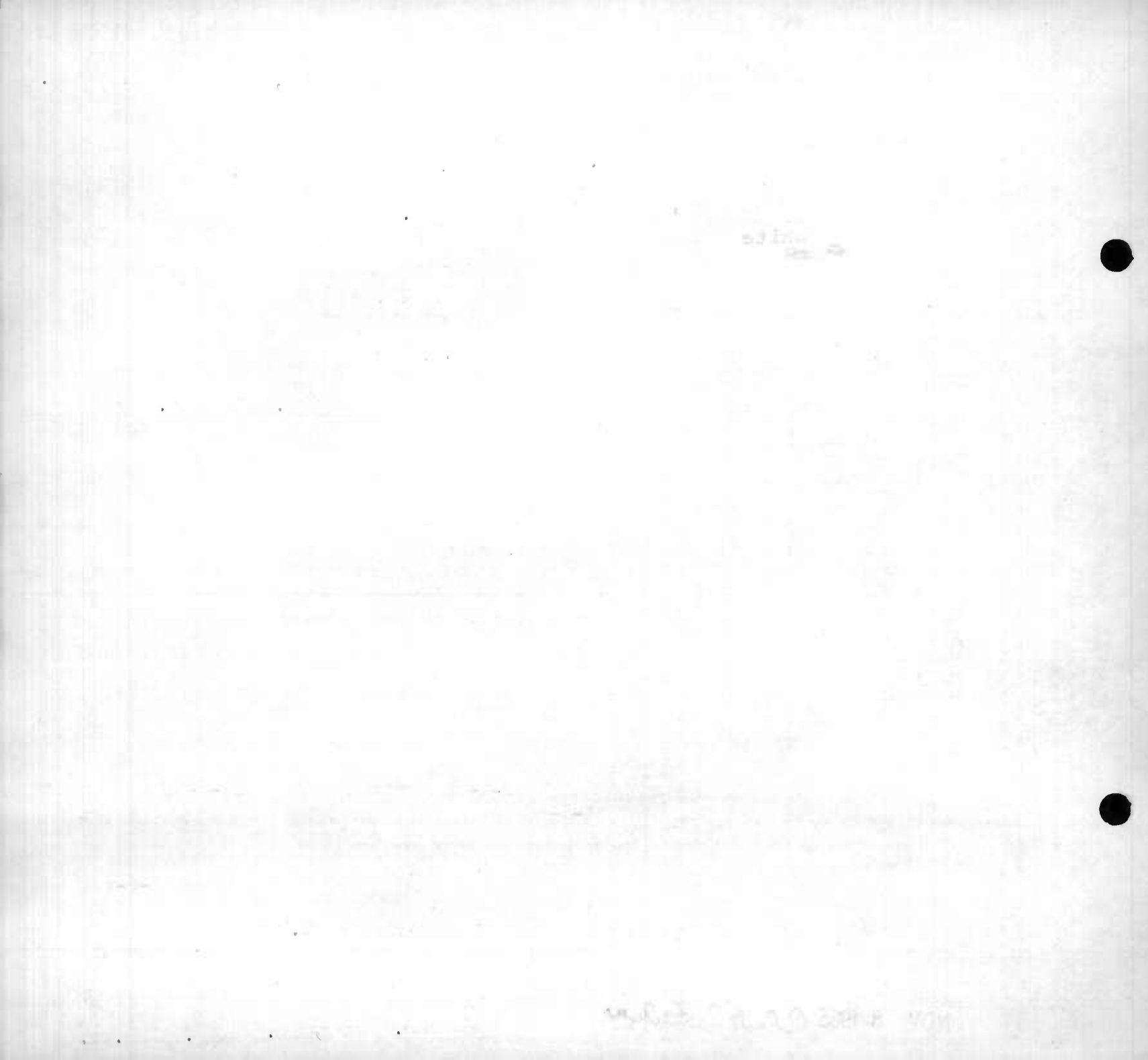




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

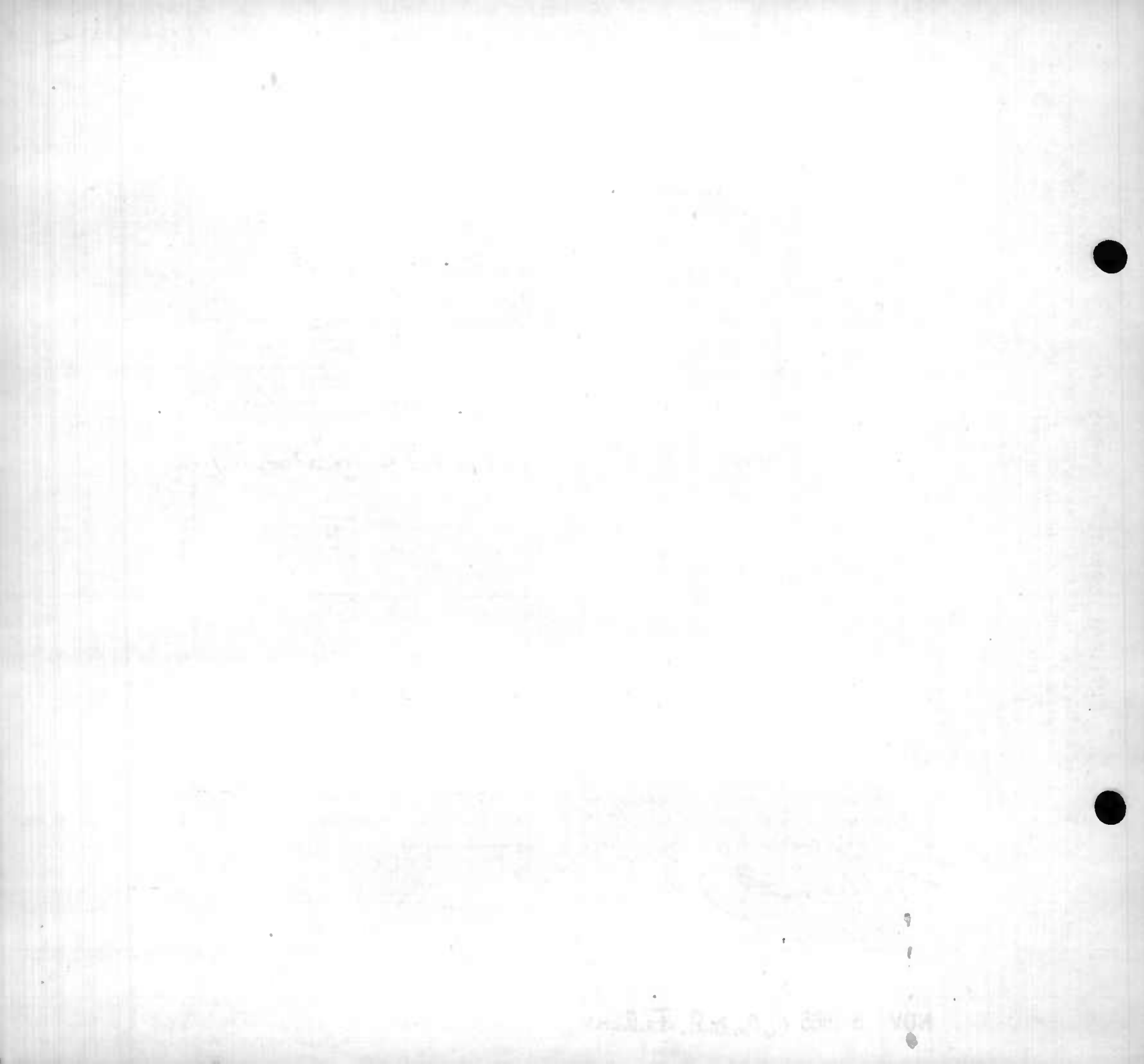
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11403	
BIRTH NO. 65 11403		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Alpha) Alfie Breeden		2. DATE AND HOUR OF DEATH November 6, 1965 11:35 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1514 Division St. Provident Hospital Baltimore, Maryland		A. STATE Maryland B. COUNTY 14-03			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 12/25/71	
13. FATHER'S NAME ? Sisk		14. MOTHER'S MAIDEN NAME unknown		9. AGE (In years last birthday) 93	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		11. BIRTHPLACE (State or foreign country) Virginia	
17. INFORMANT Donald Broyles 4 E. Main Blvd.		ADDRESS		12. CITIZEN OF WHAT COUNTRY? USA	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Irreversible Shock DUE TO (B) Old CVA DUE TO (C) ASCVD			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(Accident room death)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-6-65 19 to 11-6-65 19, that (I) (we) last saw the deceased alive on 11-6-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andre Rigaud				23B. DATE SIGNED 11-6-65	
23C. PHYSICIAN'S NAME (Type) M.D. Andre Rigaud				23D. ADDRESS M.D. 1514 Division St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/65		24C. NAME OF CEMETERY or CREMATORY Poplar Cemetery	
24D. LOCATION (City, town, or county) Cockeysville		(State) Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965	
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St.			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11404				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11404	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Walter Eugene Branch</b>				2. DATE AND HOUR OF DEATH <b>November 5, 1965 12:45 p. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division St. Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15401</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1438 Mountmor Court</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 22, 1899</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef cook</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Nannie ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Bessie Bell 748 Dolphin St.</b>			
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(Accident room death)</b>				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-5-65</b> 19 to <b>11-5-65</b> 19, that (I) (we) last saw the deceased alive on <b>11-5-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William L. Johnson</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>11-6-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>William L. Johnson</b>		23D. ADDRESS <b>1514 Division St.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/7/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Falek</b>		25C. FUNERAL DIRECTOR <b>Joseph L. Knes</b>		ADDRESS <b>2222 W. North Ave. Baltimore, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11405				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11405	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or print) <b>WOODLAND, MILTON R.</b>				2. DATE AND HOUR OF DEATH <b>11-6-65 2:15 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF (If not in hospital or institution, give street address or location) <b>11-16-65 MARYLAND</b>				A. STATE		B. COUNTY	
5. SEX <b>MALE</b>				6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	
8. DATE OF BIRTH <b>3/30/1899</b>				9. AGE (In years lost birthday) <b>66</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>late Solomon</b>				14. MOTHER'S MAIDEN NAME <b>late Lula T.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Rev. Marguerite Schwartz, 524 Random Rd</b>	
18. <b>332 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary Edema</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebrovascular Thrombosis</b>				(B) DUE TO			
				(C) <b>Hypertension</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-30-1965</b> to <b>11-6-65</b> , that (I) (we) last saw the deceased alive on <b>11-6-65 2 AM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
22A. SIGNATURE <b>Abraham G. Constantino</b>				22B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>SAUL RUBIN</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>11/9/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Salem Lutheran</b>		24D. LOCATION (City, town, or county) (State) <b>Catonsville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Witke F.D.</b>		25D. ADDRESS <b>4101 Edmondson Ave</b>	

vs 153 signed by funeral director. 11-16-65 cpb



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11406

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE

OSWALD

MOTRY

2. DATE AND HOUR PRONOUNCED DEAD

November 5, 1965

11:50 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5700 Loch Raven Blvd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9-29-1912

9. AGE (in years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Dir. Envir. Health

10B. KIND OF BUSINESS OR INDUSTRY

Balto. Health Dept.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George A.F. Motry

14. MOTHER'S MAIDEN NAME

Wilhelmina Oswald

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 11

16. SOCIAL  
SECURITY NO.

705-05-7352

17. INFORMANT

Mrs. Muriel M. Motry

ADDRESS

Above

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/5/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-8-65

23C. NAME OF CEMETERY or CREMATORY

Woodlawn

23D. LOCATION

Woodlawn

(City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 8 1965

24B. NAME OF REGISTRAR

Robert E. Fulkerson

24C. FUNERAL DIRECTOR

H.W. Jenkins &amp; Sons Co. 4905 York Rd.

ADDRESS

Balto. 12, Md.

VALLEY FORD

NOV 19 1964

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

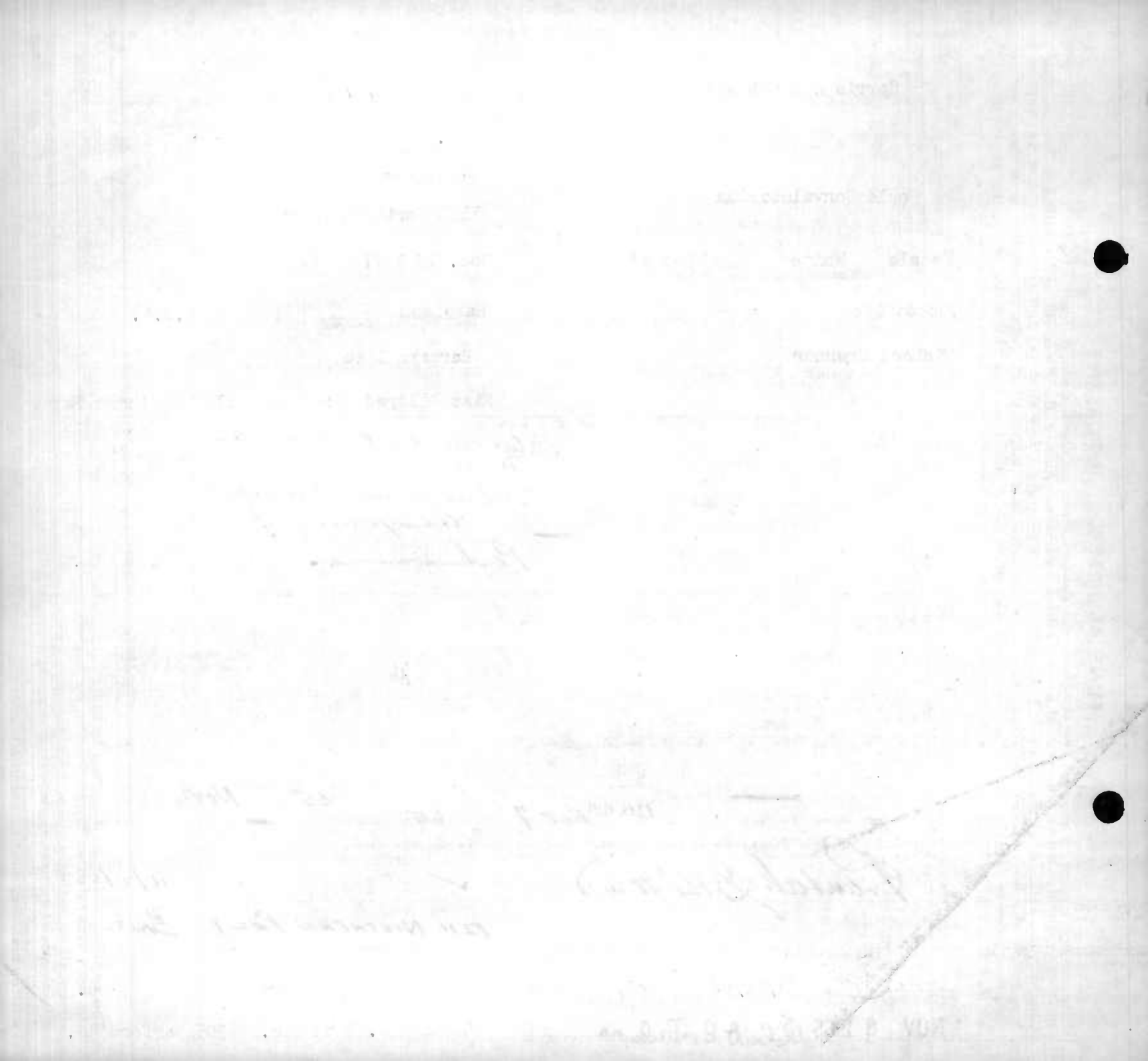
BIRTH NO. 65 11407		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11407	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DONALD P. KAHL		2. DATE AND HOUR OF DEATH 11/6/65 6:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp		A. STATE MARYLAND		B. COUNTY 9-01	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3826 EDNOR RD.			
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/17/11	9. AGE (In years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR - CLERICAL HOSPITAL
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN H. KAHL		14. MOTHER'S MAIDEN NAME LILLIAN ROHRBAUGH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-18-5466		17. INFORMANT ADDRESS SARAH W. KAHL S/A	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 163X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) CARCINOMA OF LT Lung			
ANTECEDENT CAUSES		(B) DIFFUSE METASTASIS FROM (A)		RUP	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 3 PM 10/20/65 19 65 to 6:30 AM 11/6 19 65, that (H) (we) last saw the deceased alive on 6:30 AM 11/6 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert N. Whitlock		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/6/65	
23C. PHYSICIAN'S NAME (Type) ROBERT N. WHITLOCK		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-9-65		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 11408</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 11408</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Carrie M Plantholt</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">11/7/65</span> <span style="float: right;">12:10 P.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">Gould Convalesarium</span>		A. STATE <span style="font-size: 1.1em;">Md.</span> B. COUNTY <span style="font-size: 1.1em;">27-38</span>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.1em;">Baltimore</span>			
		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.1em;">1150 Northern Parkway</span>			
5. SEX <span style="font-size: 1.1em;">Female</span>	6. RACE <span style="font-size: 1.1em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.1em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.1em;">Dec. 19 1877</span>	9. AGE (In years lost birthday) <span style="font-size: 1.1em;">87</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.1em;">Michael Brunner</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Barbara Lieb</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.1em;">Miss Mildred Plantholt 1150 Northern Pky</span>	
18. <span style="font-size: 1.2em;">422.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.1em;">Arteriosclerotic Cardiovascular Disease</span> (A) DUE TO <span style="font-size: 1.1em;">Cerebrovascular Disease &amp; Hemiparesis, et</span> (B) <span style="font-size: 1.1em;">Parkinsonism</span> (C)		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">10 yrs +</span> <span style="font-size: 1.1em;">1 week</span> <span style="font-size: 1.1em;">10 yrs +</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.1em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">No</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <span style="font-size: 1.1em;">1955</span> to <span style="font-size: 1.1em;">Nov. 19 65</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.1em;">12:10 PM Nov. 7</span> 19 <span style="font-size: 1.1em;">65</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.1em;">Robert E. Fink</span>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.1em;">11/7/65</span>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <span style="font-size: 1.1em;">1211 NORTHERN PKWY. BALTO. 12, MD.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>	24B. DATE <span style="font-size: 1.1em;">11/10/65</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Holy Redeemer</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">NOV 8 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Robert E. Fink</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">Leonard J. Ruck Inc. 5305 Harford Rd.</span>	



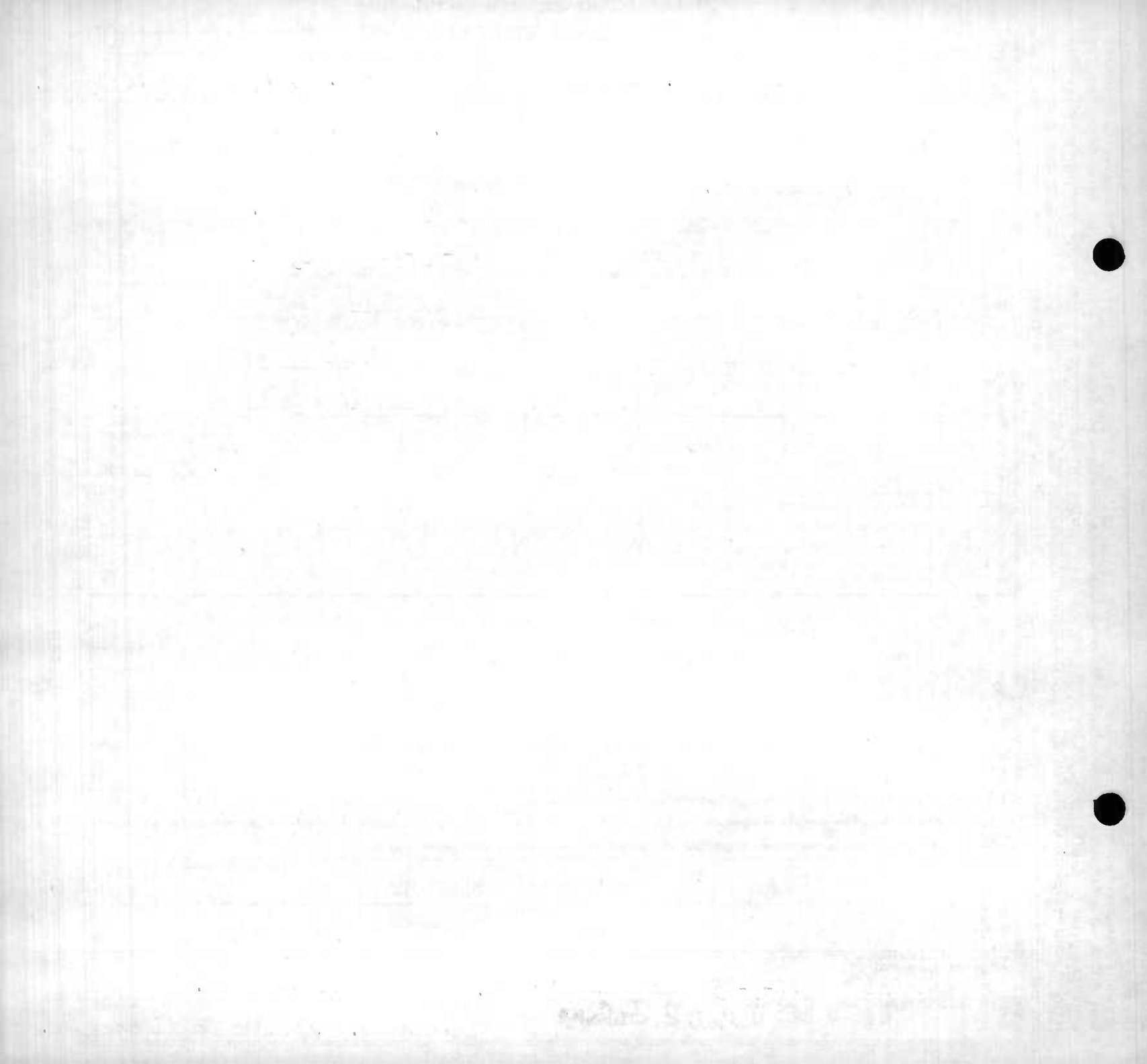


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11409	
BIRTH NO. 65 11409				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Margaret P. Kernan</i>			2. DATE AND HOUR OF DEATH <i>Nov. 6, 1965 10:25 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3105 Tyndale Ave.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-01</i>		
5. SEX <i>female</i>			6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>
8. DATE OF BIRTH <i>12-25-1880</i>			9. AGE (In years last birthday) <i>85</i>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>James Fitzgerald</i>		
14. MOTHER'S MAIDEN NAME <i>Ellen Walsh</i>			15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <i>217488401</i>			17. INFORMANT <i>Mrs Catherine Goldman</i>		
18. ADDRESS <i>same</i>			19. CAUSE OF DEATH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>Chronic Arteriosclerosis - Coronary</i> <i>Ischemic Heart Disease</i> <i>Chronic Hypertension</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> <i>6 mos.</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>no</i>					
19A. DATE OF OPERATION <i>11-4-65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 1, 1965</i> to <i>June 1, 1965</i> , that (I) (we) last saw the deceased alive on <i>11-4-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward Ruzicka</i> M.D.				23B. DATE SIGNED <i>11-8-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Edward Ruzicka</i> M.D.				23D. ADDRESS <i>800 Patterson Ave.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>11-9-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE AND BY HEALTH DEPT. <i>NOV 8 1965 Robert E. Taylor, M.D.</i>			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>			

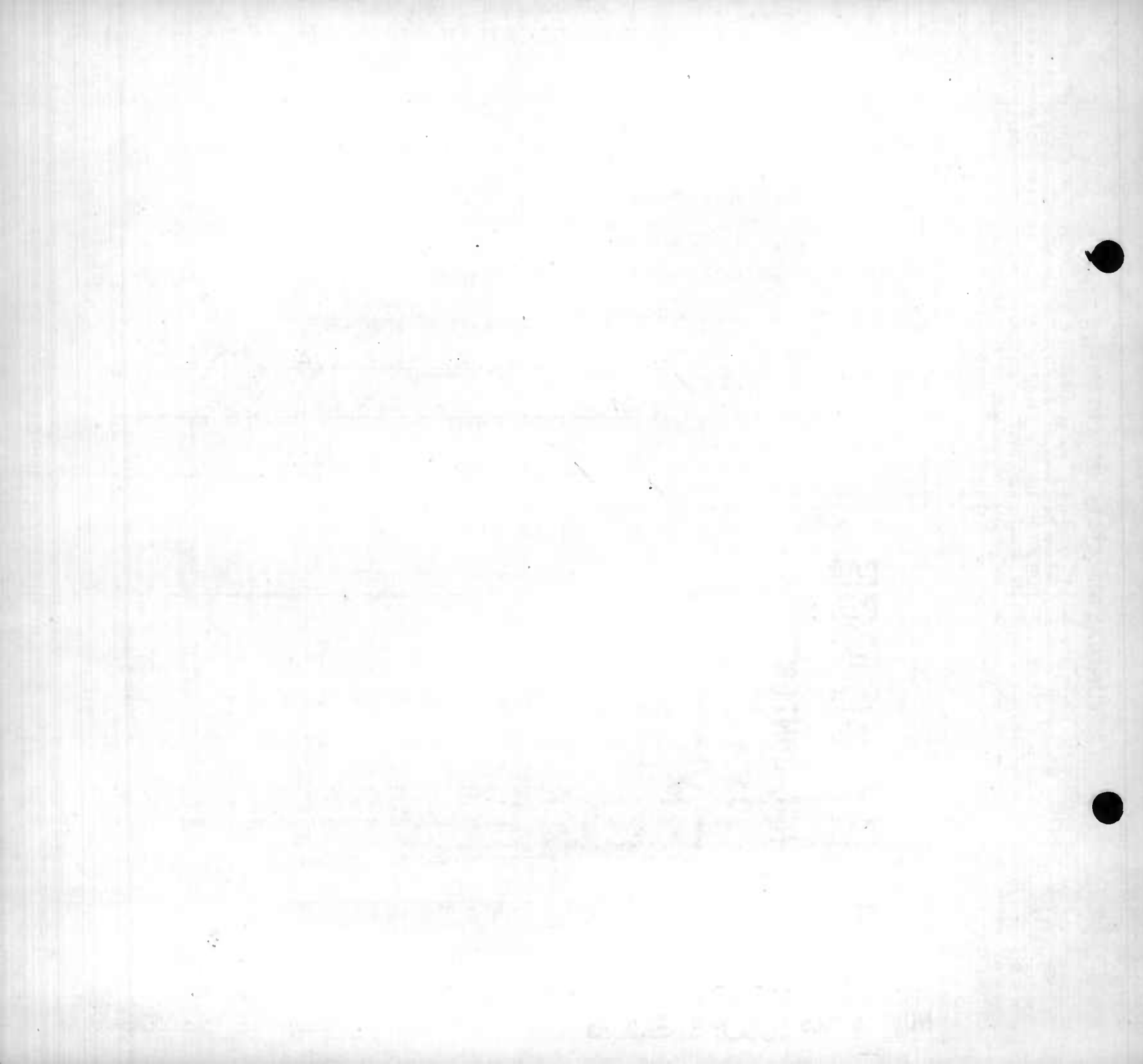




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

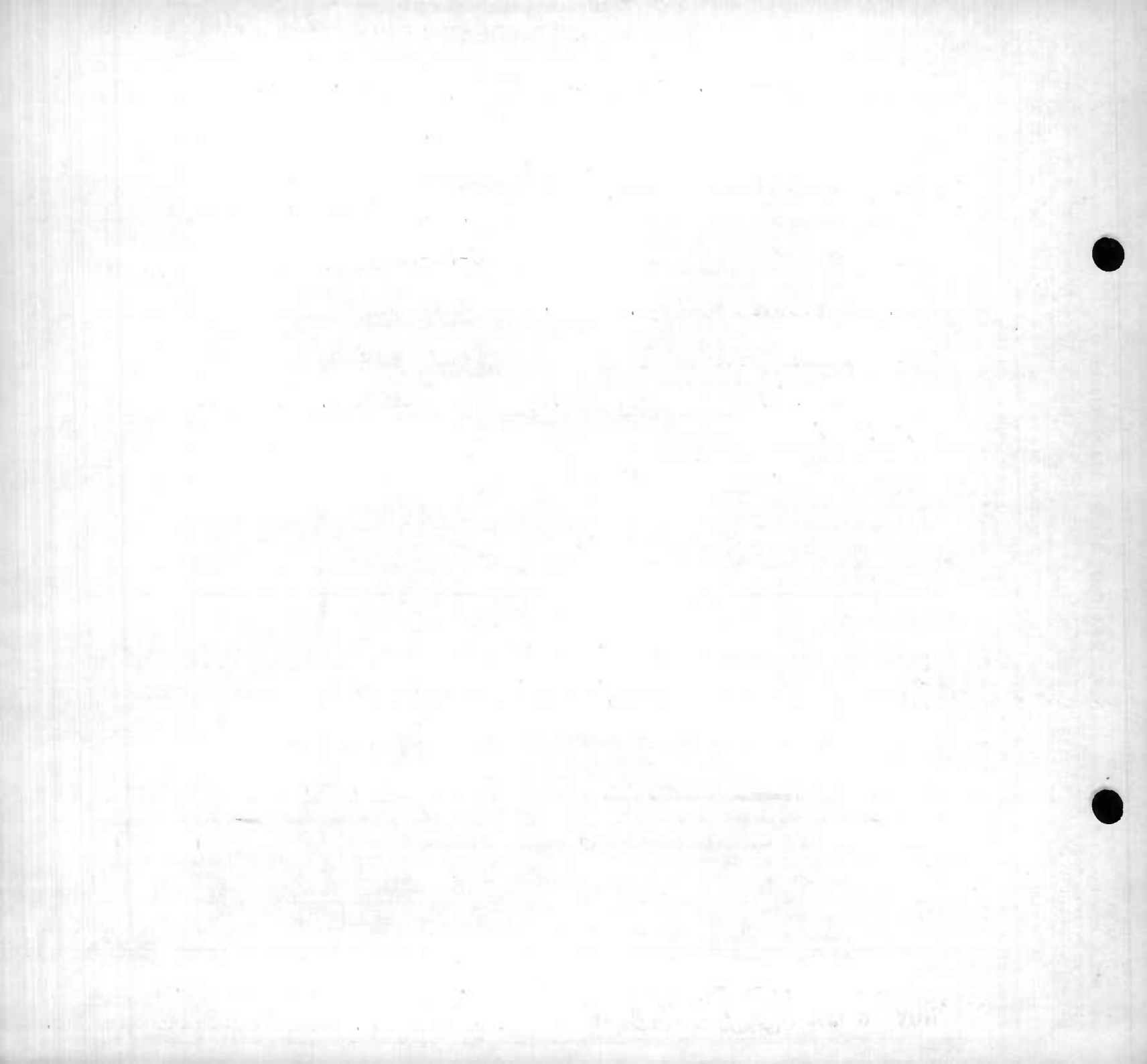
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11410</b>	
BIRTH NO. <b>65 11410</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Mildred A. Boss</b>		2. DATE AND HOUR OF DEATH <b>11-7-65 3:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>7-02</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>2403 W. Madison St.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>3-27-04</b>
9. AGE (In years last birthday) <b>61</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry W. Boss</b>	
14. MOTHER'S MAIDEN NAME <b>Martin &amp; Vorsteg</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>213032549</b>		17. INFORMANT ADDRESS <b>Hospital Chart</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO <b>HASCVD</b>	
(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-7-1965</b> to <b>11-7-1965</b> , that (I) (we) last saw the deceased alive on <b>11-7-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Dr. Hinderstul</b>		23B. DATE SIGNED <b>11-7-65</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>11-10-65</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc</b>		ADDRESS <b>Baltimore, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

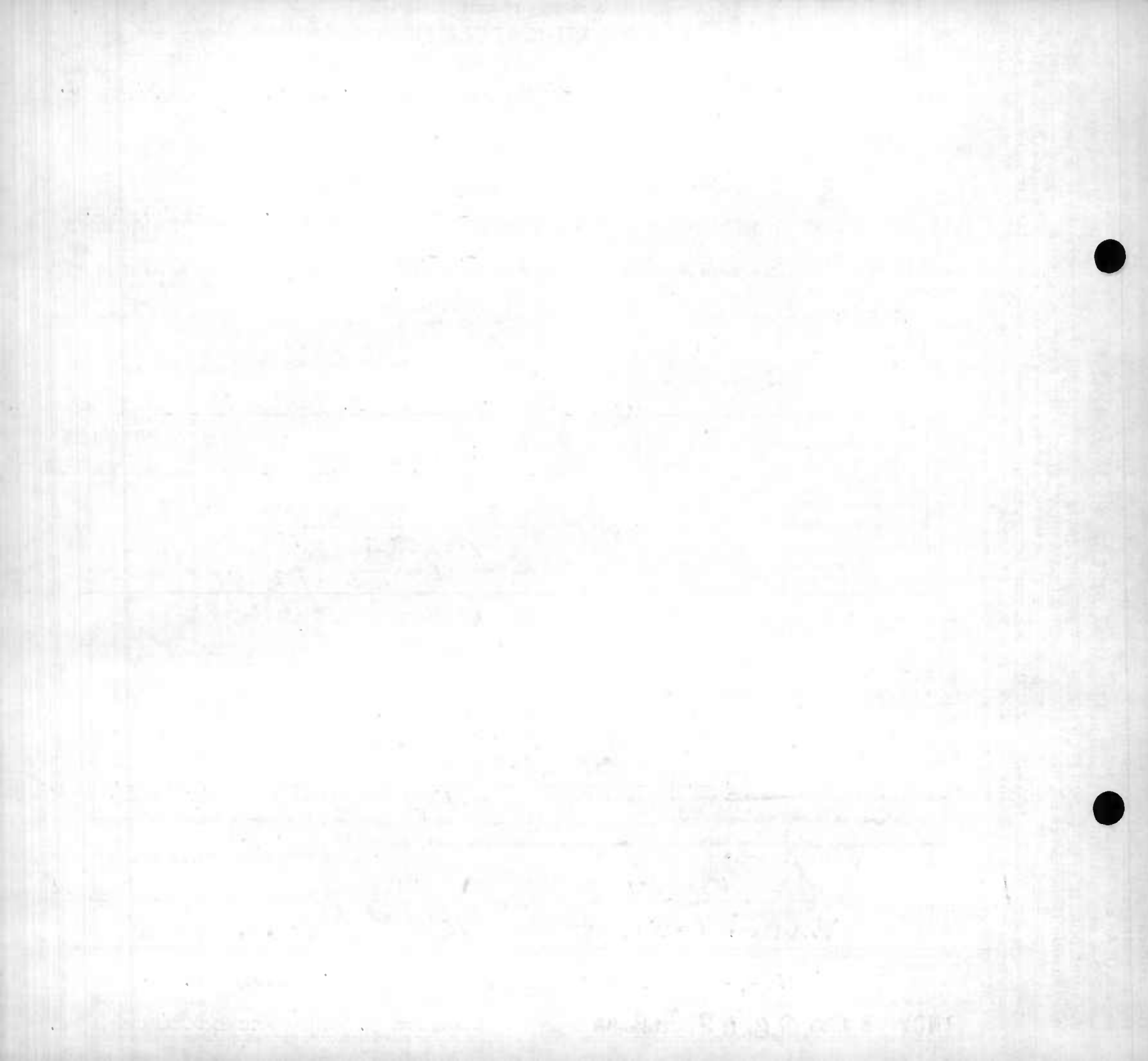
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 11411					CERTIFICATE OF DEATH					Registered No. 65 11411				
1. NAME OF DECEASED (Type or Print) <i>Lewis A. Schaffner</i>					2. DATE AND HOUR OF DEATH <i>Nov. 7, 1965</i> <i>2:30 P. M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, 34</i>				
					D. STREET ADDRESS (If rural, give location) <i>8345 Hillendale Road</i>					5300				
5. SEX <i>male</i>		6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>8-18-1893</i>		9. AGE (In years last birthday) <i>72</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Bethlehem Steel Co.</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					13. FATHER'S NAME <i>Joseph Schaffner</i>					14. MOTHER'S MAIDEN NAME <i>Ida May Dixon</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW 1</i>					16. SOCIAL SECURITY NO. <i>273090125</i>					17. INFORMANT <i>Mrs Carrie M. Schaffner</i>				
ADDRESS <i>same</i>														
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO (B) <i>Arteriosclerotic Heart Disease</i> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>12 yrs</i>				
MEDICAL CERTIFICATION														
19A. DATE OF OPERATION <input type="radio"/>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (the <del>physician</del> ) attended the deceased from <i>Nov 18 1961</i> to <i>Nov 7 1965</i> , that (I) <del>last</del> saw the deceased alive on <i>Oct 29 1965</i> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did)</del> (did not) view the body after death.														
23A. SIGNATURE <i>Joseph F. Li Pira</i> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>11/8/65</i>				
23C. PHYSICIAN'S NAME (Type) <i>Joseph F. Li Pira</i> M.D.					23D. ADDRESS <i>8400 Rock Raven Blvd. Baltimore, Md.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>					24B. DATE <i>11-10-65</i>					24C. NAME of CEMETERY or CREMATORY <i>Sacred Heart Cem.</i>				
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>														
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Farber</i>					25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>				
ADDRESS														



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 11412</span>	
BIRTH NO. <span style="float: right;">65 11412</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Henrietta Fair</i>		2. DATE AND HOUR OF DEATH <i>Nov. 5, 1965 15:30 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Gould Convalesarium</i>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>26-10</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>Formerly of 4 S. Highland Ave.</i>			
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>3-19-1883</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Louis Miller</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Miller</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212076520B</i>		17. INFORMANT <i>Mrs Ethel F. Porter</i>	
ADDRESS <i>1525 Greendale Rd.</i>					
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO <i>Arteriosclerosis</i> <i>Cardio Vascular Disease</i> (B) DUE TO <i>Myocardial Insufficiency</i> <i>Pulmonary Embolism</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>24</i> <i>20 min.</i>	
19A. DATE OF OPERATION <i>Nov - 29 - 1965</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Nov - 29 - 1965</i> to <i>Nov - 5 - 1965</i> , that (I) ( <del>last</del> ) last saw the deceased alive on <i>Nov - 5 - 1965</i> and that in (my) ( <del>the</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. <i>No</i>					
23A. SIGNATURE <i>Wm G. Geyer</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Nov - 6 - 65</i>	
23C. PHYSICIAN'S NAME (Type) <i>WM G. GEYER</i>		23D. ADDRESS <i>156 N. MITHON - AVE.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>11-9-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>	
ADDRESS <i>Baltimore, Md.</i>					

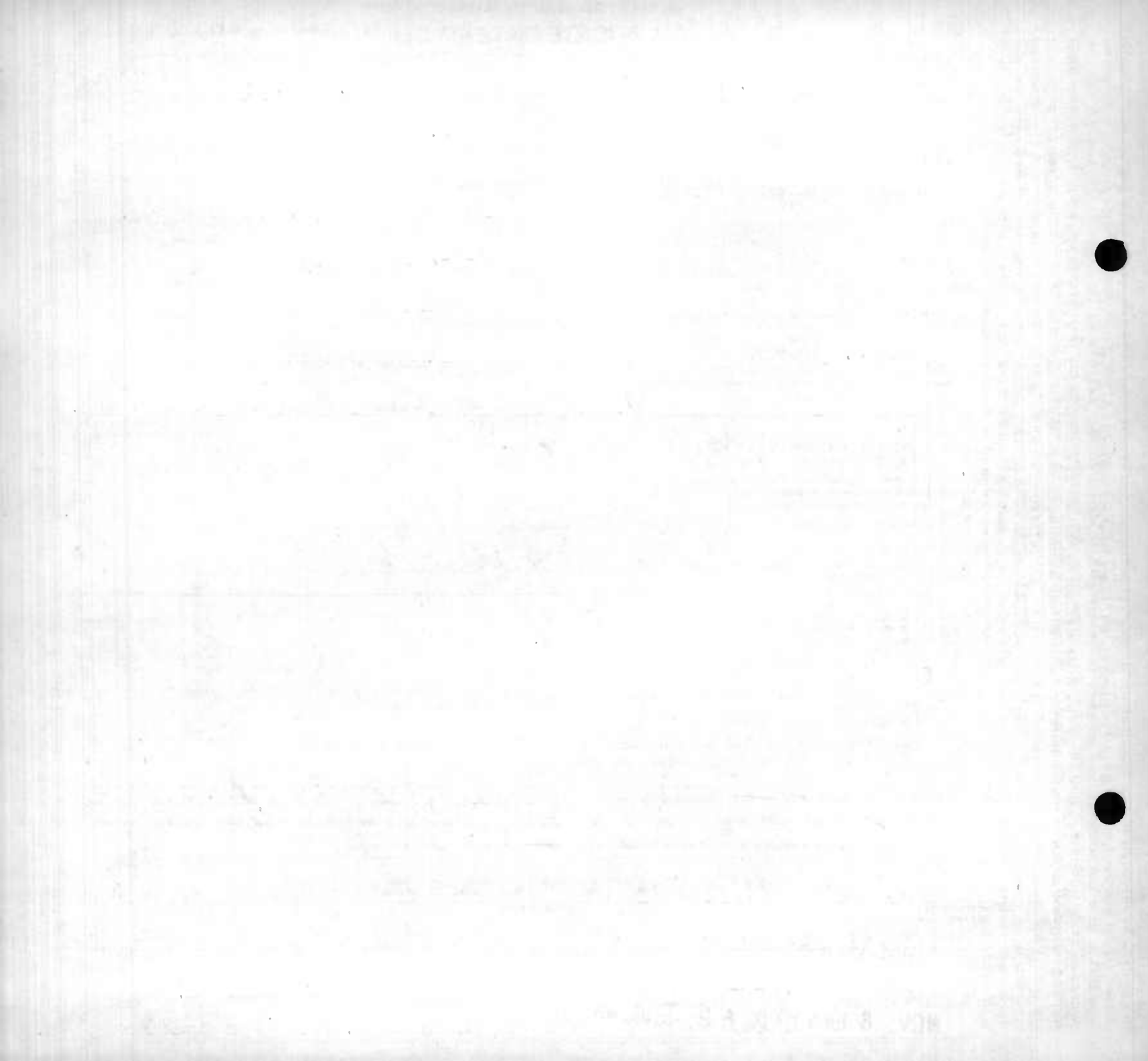




# FUNERAL DIRECTOR: IMPORTANT

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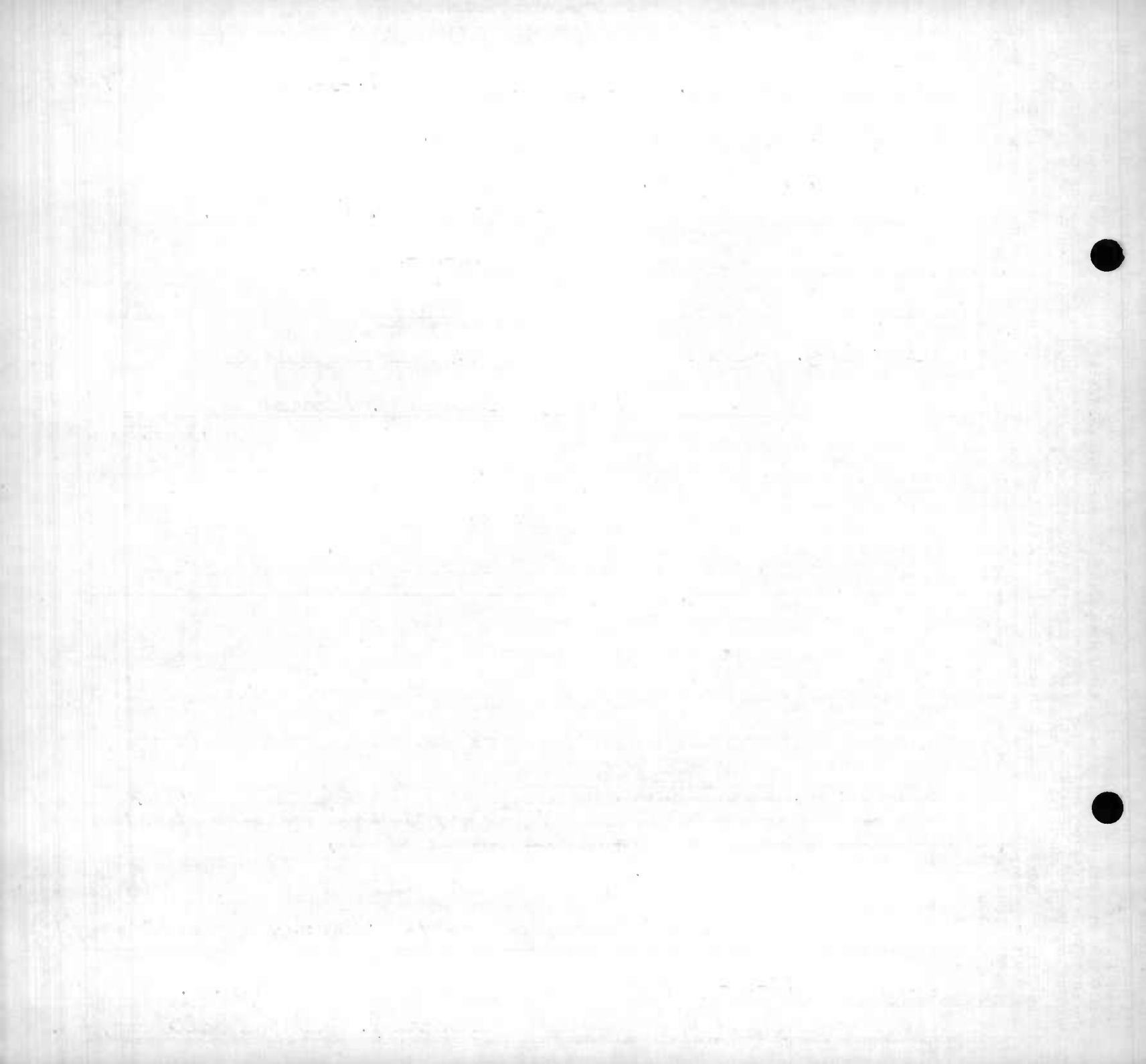
BIRTH NO. <b>65 11413</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 11413</b>	
1. NAME OF DECEASED (Type or Print) <i>Eva M. Krauss</i>			2. DATE AND HOUR OF DEATH <i>Nov. 5, 1965</i> <b>3:45 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Harford Gardens Nursing Home</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-03</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>Formerly of 2401 Hermosa Ave.</i>		
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>1-4-1880</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John W. Gibson</i>		14. MOTHER'S MAIDEN NAME <i>Melvina Benton</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213037614D</i>		17. INFORMANT <i>Mrs Ethel Ebley 4308 Glenarm Ave.</i>	
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic Heart Disease Ch Congestive failure.</i> (B) DUE TO <i>Generalized Arteriosclerosis</i> (C) <i>status pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>July 65</i> 19 <i>55</i> to <i>Nov 5</i> 19 <i>65</i> , that (I) ( <del>we</del> ) lost saw the deceased alive on <i>Nov 3</i> 19 <i>65</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Donald W. Minter</i> DONALD W. MINTER				23B. DATE SIGNED <i>Nov 8 1965</i> BALTIMORE	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<i>burial</i>		<i>11-8-65</i>		<i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
<i>Baltimore, Md.</i>		<i>NOV 8 1965</i>		<i>Robert E. Fisher</i>	
25A. FUNERAL DIRECTOR		25B. ADDRESS			
<i>Leonard J. Ruck Inc</i>		<i>Baltimore, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11414	
BIRTH NO. 65 11414		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Howard J. Palardy, Sr.</i>		2. DATE AND HOUR OF DEATH <i>11-8-1965</i> <i>9:00 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-34</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4003 Apt. 1 White Ave.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>4003 Apt. 1 White Ave.</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>10-12-1890</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Francis G. Palardy</i>		14. MOTHER'S MAIDEN NAME <i>Mary Louise Becelle</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212106350</i>	17. INFORMANT <i>Frances A. Palardy</i>		ADDRESS <i>same</i>
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Coronary Thrombosis</i> DUE TO (B) <i>Atherosclerotic C.V. disease &amp; Angina</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>9/28/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>9/23 1953</i> to <i>11/6 1965</i> , that (I) ( <del>was</del> ) last saw the deceased alive on <i>9/28 1965</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>L.B. Stevens</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>11/8/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>L.B. STEVENS</i>		23D. ADDRESS <i>3400 ERDMAN AVE. BALTIMORE, MD 21213</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>	24B. DATE <i>11-10-65</i>	24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11415				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11415	
1. NAME OF DECEASED (Type or Print) <b>John D. Alford</b>				2. DATE AND HOUR OF DEATH <b>11-4-65 13:50 P. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>6-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1834 E. Fayette St. #21231</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8-18-08</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>South Caroline</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charlie</b>				14. MOTHER'S MAIDEN NAME <b>Lula</b>				17. INFORMANT ADDRESS <b>#21224 RECORDS-BCH-4940 Eastern Avenue</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.					
18. I <b>3-26-X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bronchiectasis</b> (A) DUE TO <b>Acute Bronchitis</b> (B) DUE TO <b>2 years</b> (C) DUE TO <b>30 days</b>				INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>9-30-65</b> to <b>11-4-65</b> 19 <b>11-4-65</b> 19 <b>11-4-65</b> 19 that (I) (we) lost saw the deceased alive on <b>11-4-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>William B. Cutts</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-4-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. William B. Cutts</b>				23D. ADDRESS <b>BCH-4940 Eastern Avenue-Baltimore, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-8-1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Cornet Cent</b>		24D. LOCATION (City, town, or county) (State) <b>Lanval Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Choy Wilson 1001 Bryant Ave</b>		ADDRESS			

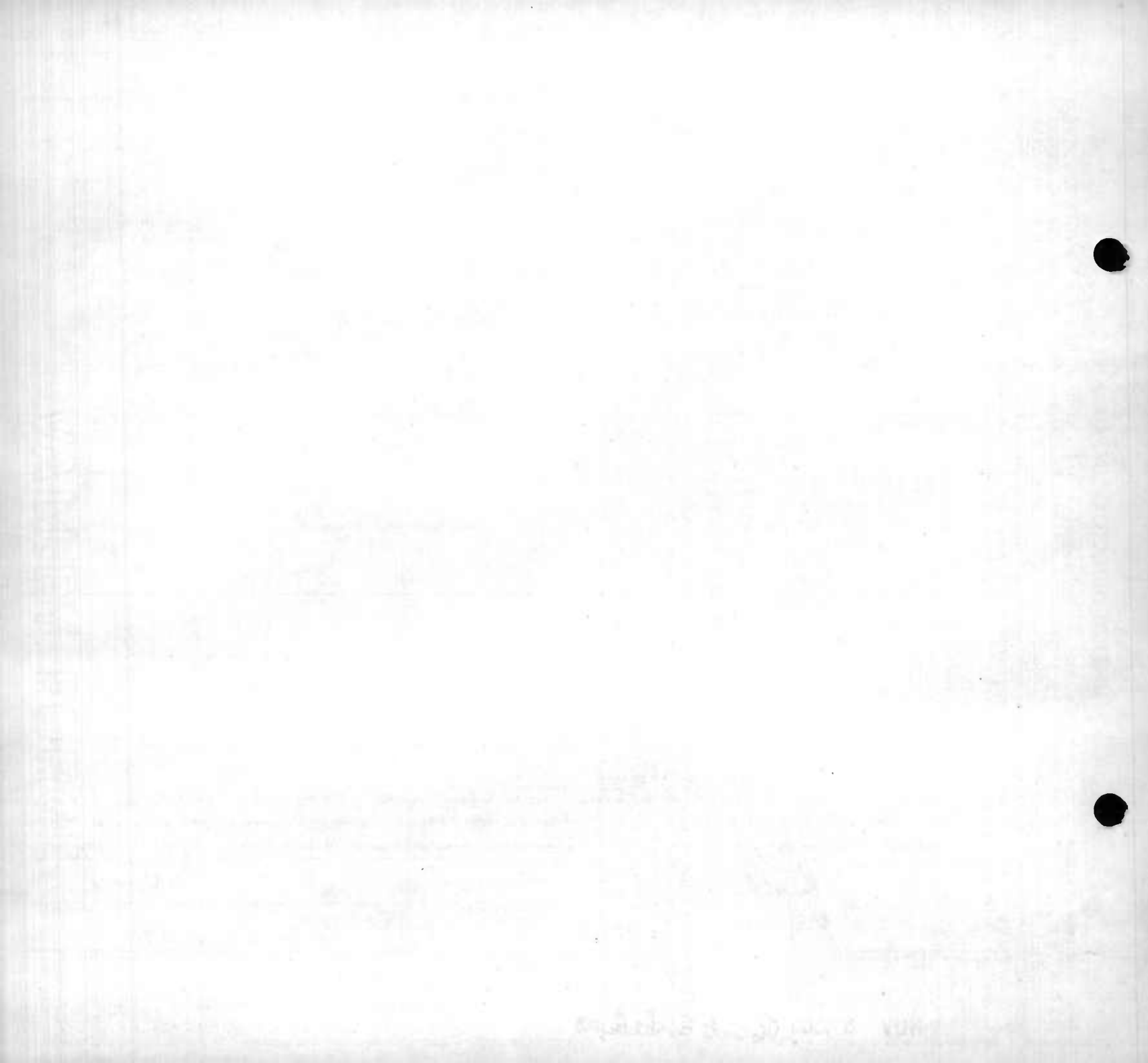


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11416</b>	
BIRTH NO. <b>65 11416</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Carrie Edwards</b>		2. DATE AND HOUR OF DEATH <b>Nov. 2, 1965 11<sup>15</sup> P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Home - 3005 W. LANVALE ST.</b>		A. STATE <b>Maryland</b> B. COUNTY <b>16-06</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>3005 W. LANVALE ST.</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 8, 1888</b>	9. AGE (In years last birthday) <b>76</b>	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Easter Shore, Md</b>	
13. FATHER'S NAME <b>Moses Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Alice Saulter</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Northa Odums</b>	
				ADDRESS <b>SAME</b>	
18. <b>422.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular disease</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 19 65</b> to <b>Nov 2 1965</b> , that (I) (we) last saw the deceased alive on <b>October 30 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Royston R Scott</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Nov 6, 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROYSTON SCOTT</b>		23D. ADDRESS <b>1801 W. BELLEVILLE ST</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-6-65</b>		24C. NAME of CEMETERY or CREMATORY <b>MT. Auburn Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>		25C. FUNERAL DIRECTOR <b>E. O. Wilson</b>	
				ADDRESS <b>1000 Brantley Ave.</b>	

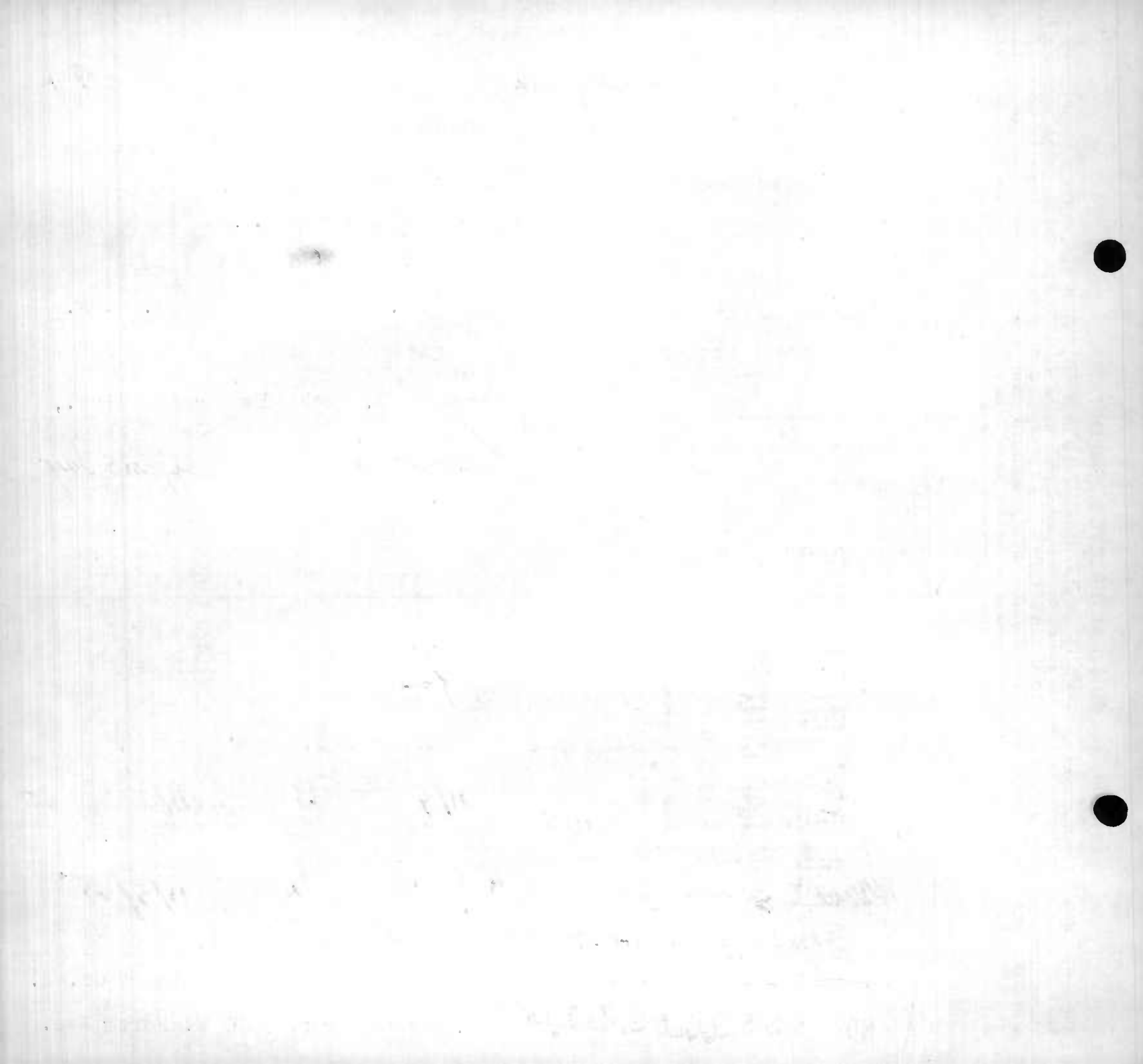




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11417				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11417	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Margaret Buckingham</i>		2. DATE AND HOUR OF DEATH <i>11/5/65</i> <i>2:35 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>				A. STATE <i>MARYLAND</i>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
				D. STREET ADDRESS (If rural, give location) <i>4100 BRENDAN AVE.</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>6-7-99</i>	9. AGE (In years) <i>66</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Michael Foster</i>				14. MOTHER'S MAIDEN NAME <i>CATHERINE HESS</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Margaret J. Heck 4100 Brendan Ave.,</i>			
18. <i>493X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>approx 5 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes.</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/4</i> 19 <i>65</i> to <i>11/5</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>11/5</i> 19 <i>65</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Daniel G. Robinhold</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/5/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>DANIEL G. ROBINHOLD</i>				23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-9-1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, MA</i>		25C. FUNERAL DIRECTOR <i>G. Howard Strong</i>		ADDRESS <i>3207 W. North Ave.</i>	



# FUNERAL DIRECTOR: IMPORTANT

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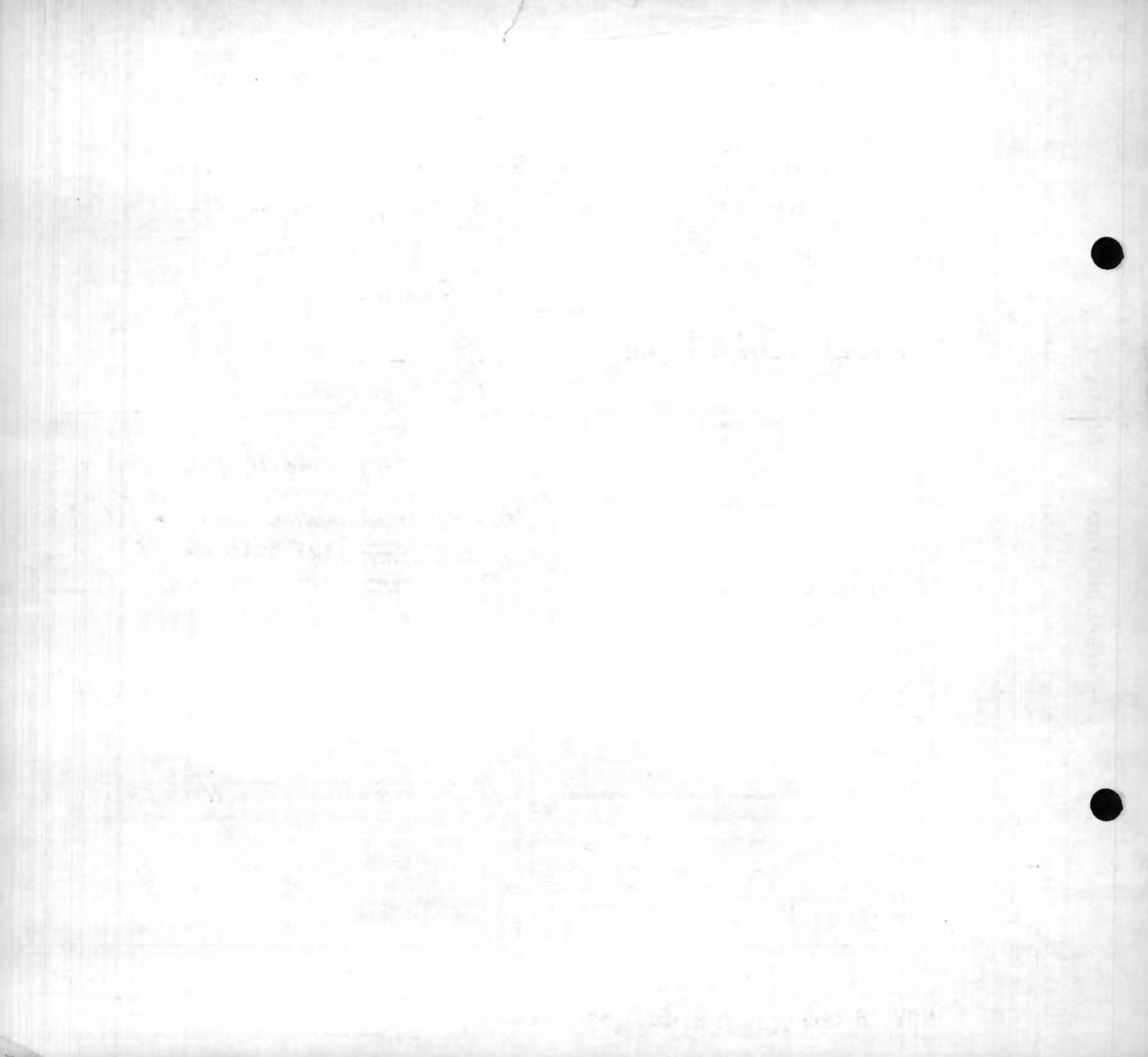
BIRTH NO. <i>Penna.</i> <b>65 11418</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 11418</b>	
M.E. CASE NO. <b>65 11418</b>		1. NAME OF DECEASED (Type or Print) <i>PRICE, SCOTTA.</i>		2. DATE AND HOUR OF DEATH <i>11-3-65 3:25 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital 601 Broadway N. St. Baltimore, Md.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>PENNSYLVANIA</b> B. COUNTY <i>V-35</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Oxford</i> D. STREET ADDRESS (If rural, give location) <i>P.O. Box 223</i>			
5. SEX <i>M</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>never married</i>	8. DATE OF BIRTH <i>4-7-65</i>	9. AGE (In years last birthday) <i>5 m. 27 d.</i>	If Under 1 Yr. Months: Days: Hours: Min. <i>5 27</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Dean Price</i>			
14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		15. SOCIAL SECURITY NO.		16. INFORMANT ADDRESS	
17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>122.2.1</i>		CAUSE OF DEATH (A) <i>Respiratory Distress</i> (B) <i>Pneumonia</i> (C) <i>Pneumocystis carinii</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Swiss type agammaglobulinemia</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Complete</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-1-65</i> 19 <i>65</i> to <i>11-3</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>11-3-65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>L. J. CASAZZA</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>11-3-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>L. J. CASAZZA</i>		23D. ADDRESS <i>1632 McElderry St. Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11/6/1965</i>		24C. NAME of CEMETERY or CREMATORY <i>OXFORD</i>	
24D. LOCATION (City, town, or county) (State) <i>OXFORD PA.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farkas</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Ralph M Reed, Rising Sun, Md</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 11419		CERTIFICATE OF DEATH		65 11419	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>PAULA SACHS</b>		2. DATE AND HOUR OF DEATH <b>11-4-65 8<sup>10</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BALTO.</b> B. COUNTY <b>MD</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. 15, MD</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTO 5000 GREENSPRING AVE BALTO. 15, MD</b>		D. STREET ADDRESS (If rural, give location) <b>3712 ARCADIA AVE (15)</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b> , DIVORCED (specify)	8. DATE OF BIRTH <b>4-29-91</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>DAVID BANFMAN</b>		14. MOTHER'S MAIDEN NAME <b>HILDA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARTIN HESS 4712 BYRON RD</b>	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MYOCARDIAL INFARCTION -</b> <b>ARRHYTHMIC FIBRILLATION</b> <b>HYPERTENSIVE ART. SCLEROTIC</b> <b>CARDIO-VASCULAR DISEASE</b>		CAUSE OF DEATH (A) DUE TO <b>PULMONARY INFARCTION</b> (B) DUE TO <b>MYOCARDIAL INFARCTION -</b> <b>ARRHYTHMIC FIBRILLATION</b> (C) <b>HYPERTENSIVE ART. SCLEROTIC</b> <b>CARDIO-VASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 HOUR</b> <b>2 DAYS</b> <b>10 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-2-65</b> 19 to <b>11-4-65</b> 19, that (I) (we) last saw the deceased alive on <b>11-4-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louise A. Snyder</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-4-65</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/5/65</b>		24C. NAME of CEMETERY or CREMATORY <b>CHEVRA ANNAVAS CHESED</b>	
24D. LOCATION (City, town, or county) (State) <b>Handallstown Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Track Lewis Inc. 2100 EUTAW PL</b>	
25D. ADDRESS					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO. 65 11420		CERTIFICATE OF DEATH		Registered No. 65 11420	
1. NAME OF DECEASED (Type or Print) <b>LIBBIE MISLER</b>				2. DATE AND HOUR OF DEATH <b>11-4-65</b> <b>4:15 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME &amp; HOSPITAL BALTIMORE, Md. 21231</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>U.S.A.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1719 E. FAIRMOUNT AVE.</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>7-15-25</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>POLISH</b>			
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>SALMAN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>420.11</b> <b>Pulmonary Edema</b>				CAUSE OF DEATH (A) DUE TO <b>Pulmonary Edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b>				(B) DUE TO <b>Myocardial Infarction</b>		Interval <b>several days</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 30</b> 19 <b>65</b> to <b>Nov 4</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>Nov 4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Ephraim B. Barzaga</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-4-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>EPHRAIM B. BARZAGA</b> M.D.				23D. ADDRESS <b>CHURCH HOME &amp; Hosp. BALTO. 31, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/7/65</b>		24C. NAME of CEMETERY or CREMATORY <b>WORKMAN'S CIRCLE</b>		24D. LOCATION (City, town, or county) (State) <b>GERMAN HILL Rd. BALTO Co.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Jack Lewis Inc. 2100 EUTAW PLACE BALTO. CITY Md.</b>					

Epstein, B. BARZACH Church Home & Hosp. Baltimore  
11-4-42

No

Proposed for separate service  
Postmaster General

unknown

German

Board

First Lt

1st & 2nd

1st Lt

CHURCH HOME & HOSPITAL  
BALTIMORE MD 21201

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

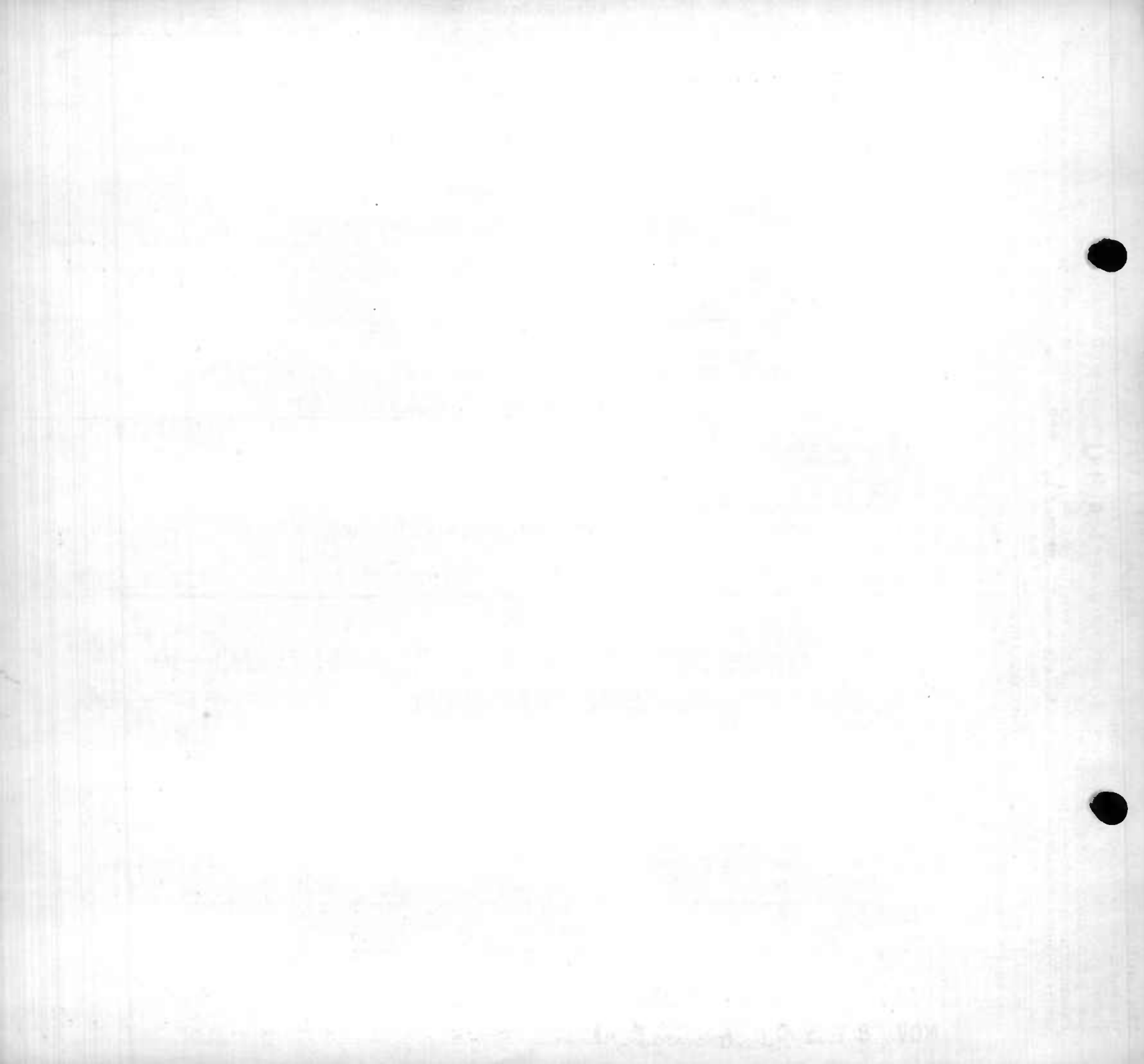
BIRTH NO. 65 11421		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11421	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ERNEST JONES</b>			2. DATE AND HOUR OF DEATH <b>11-6-65</b>   <b>3.00</b> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>13-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3412 BEECH AVENUE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>MARRIED</b>	8. DATE OF BIRTH <b>1-17-15</b>	9. AGE (In years lost birthday) <b>50</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>EMORY JONES</b>			
14. MOTHER'S MAIDEN NAME <b>Carrie Espy.</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>2nd W.W.</b>			
16. SOCIAL SECURITY NO. <b>21207 4268</b>		17. INFORMANT ADDRESS <b>Shirley V. Jones. 3412 Beech Ave</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>45-IX I</b> <b>CAUSE OF DEATH</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>Renal failure (Tuberc. Nephritis) 10 days</b> (B) <b>Pneumonia pneumonia 16 days</b> (C) <b>Dissecting thoracic aneurysm 17 days</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pneumothorax on R side 10 days</b>					
19A. DATE OF OPERATION <b>10/14/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Dissecting Aortic Aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 1</b> 19 <b>65</b> to <b>Nov 6</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>11/6/65 4:00 AM</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bruce W. Weissman</b> M.D.			23B. DATE SIGNED <b>11/6/65</b>		23C. PHYSICIAN'S NAME (Type) <b>BRUCE W. WEISSMAN</b> M.D.
23D. ADDRESS <b>Johns Hopkins Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>11/9/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Justin E. Donovan</b> 3818 Polk Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11422</b>	
BIRTH NO. <b>65 11422</b>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Scheckells August</b>		2. DATE AND HOUR OF DEATH <b>3:35 AM Nov. 7 1965</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>		A. STATE <b>Maryland</b> B. COUNTY <b>19-03</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b>			
		D. STREET ADDRESS (If rural, give location) <b>1302 W. Lombard St.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>2/5/09</b>	9. AGE (In years last birthday) <b>56</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter?</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Balto.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Harry Scheckells</b>		14. MOTHER'S MAIDEN NAME <b>Vinty</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>214-01-3498</b>		17. INFORMANT <b>Patient</b>	
18. <b>527.21</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Alveolar cap block 20 to Cereg Lung area &amp; the</b>		<b>?</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>—</b>			
(C) <b>—</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>"YES"</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4:00 PM 11/3/65</b> 19 to <b>3:35 AM 11/7/65</b> 19, that (I) (we) last saw the deceased alive on <b>11/7/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P.P. Tosker</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/7/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>P.P. Tosker</b>		23D. ADDRESS M.D. <b>University Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/10/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Tashman</b>		25C. FUNERAL DIRECTOR <b>Joseph A. Zarnier</b>	
				ADDRESS <b>2635 Conkling St</b>	



65 11423

BALTIMORE CITY HEALTH DEPARTMENT

65 11423

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SARAH IDA WOLF

2. DATE AND HOUR PRONOUNCED DEAD

November 5, 1965 9:55 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2623 W. Belvedere Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

9-13-1921

9. AGE (In years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

WAITRESS

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO. MD

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

LOUIS

14. MOTHER'S MAIDEN NAME

JENNIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-14-0267

17. INFORMANT

ADDRESS

CHARLES HAMAN - 3807 WASHINGTON AVE

18.

E 902.10

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Craniocerebral Injury.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

(I)  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

2623 W. Belvedere Avenue 27-17

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11 1 '65 P

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fall from chair (history of previous  
fall 3 months ago).

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
11/5/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/7/65

23C. NAME OF CEMETERY or CREMATORY

Rosedale

23D. LOCATION

Baltimore

(City, town, or county)

(State)

MD

24A. DATE REC'D BY HEALTH DEPT.

NOV 9 1965

24B. NAME OF REGISTRAR

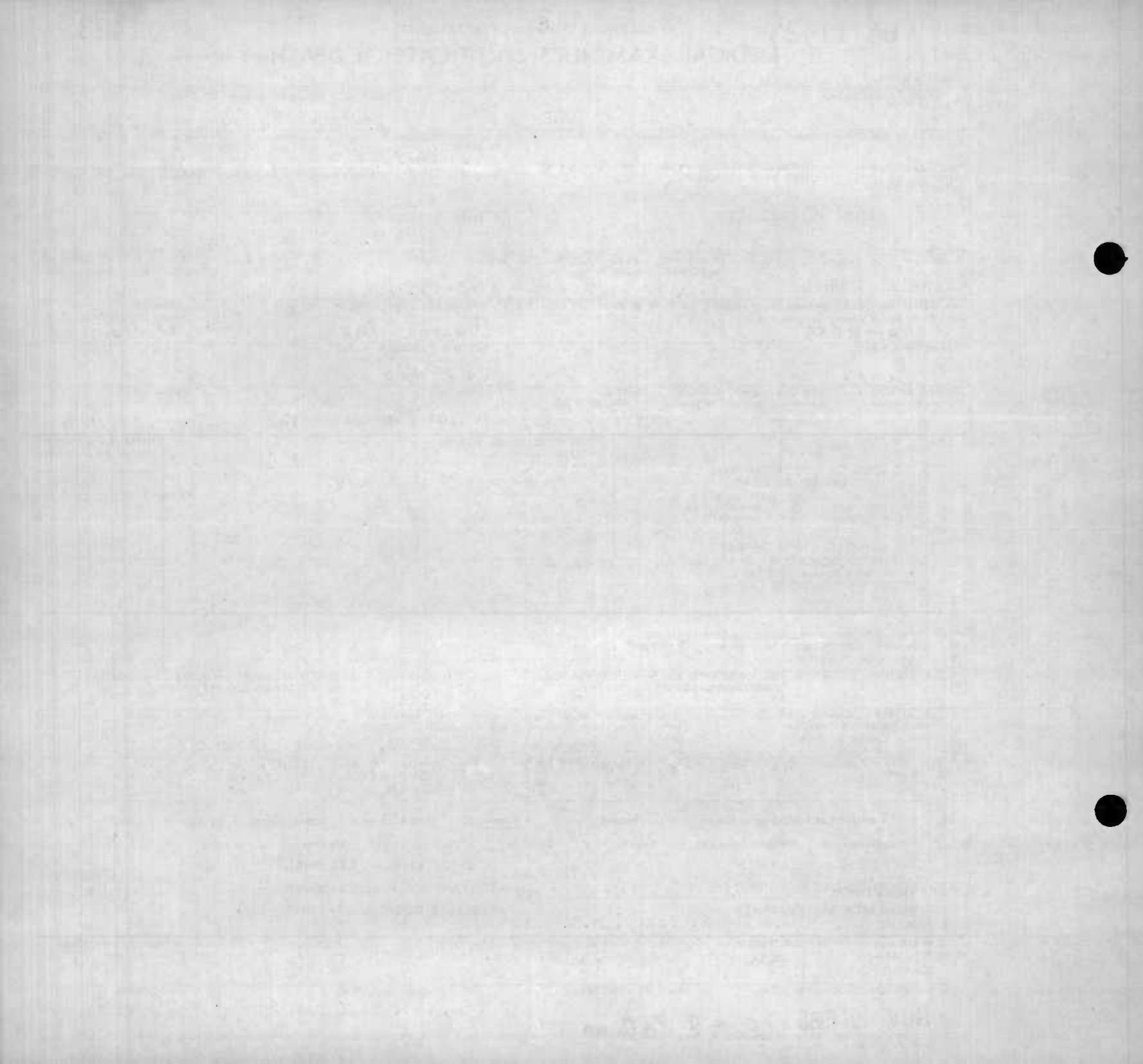
Robert E. Faldut

24C. FUNERAL DIRECTOR

Sylvan S. Lewis &amp; Son 3319 Olympia Ave

ADDRESS





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11424		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11424	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Brown George F.</b>		2. DATE AND HOUR OF DEATH <b>11-5-65 11 PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospital</b> <b>4940 Eastern Avenue 21224</b>		A. STATE <b>B. COUNTY</b> <b>616 N Decker Ave</b> <b>Baltimore Maryland</b>		D. STREET ADDRESS (If rural, give location)	
6. SEX <b>M</b>	7. RACE <b>White</b>	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>	9. DATE OF BIRTH <b>8-8-94</b>	10. AGE (In years last birthday) <b>71</b>	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Elite Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John V Brown</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Geblein</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-03-6231A</b>		17. INFORMANT ADDRESS <b>RECORDS:BCH 4940 Eastern Avenue 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>578X 1-201X</b>		CAUSE OF DEATH (A) <b>Small Bowel Perforation</b> DUE TO (B) <b>Hodgkins Disease</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Hodgkins Disease</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-28-65</b> 19 to <b>11-5-65 at 11 PM</b> , that (I) (we) last saw the deceased alive on <b>11 PM</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Steve L Johnson</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-5-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>STEVE L JOHNSON</b>		23D. ADDRESS <b>1620 McELDERRY ST. BALT.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/9/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11425		CITY HEALTH DEPARTMENT		Registered No. 65 11425	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Neubert David</i>		2. DATE AND HOUR OF DEATH <i>11/6/65 11:40 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. AGE (In years last birthday) <i>79</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY <i>7-05</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
<i>BON SECOURS</i>		<i>BALTIMORE</i>		<i>2019 McELDERA ST.</i>	
6. SEX <i>M</i>	7. RACE <i>W</i>	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	9. DATE OF BIRTH <i>11-15-85</i>	10. AGE (In years last birthday) <i>79</i>	11. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
<i>RETIRED</i>		<i>Neubert Seafood Co.</i>		<i>Baltimore, Md.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<i>JOHN NEUBERT</i>		<i>SOPHIA TARONER</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-247697</i>		17. INFORMANT ADDRESS	
		<i>Marie Vanko, dght, above</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<i>Congestive heart failure</i>		<i>years</i>	
ANTECEDENT CAUSES		<i>Arteriosclerotic cardiovascular disease</i>		<i>years</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
<i>2</i>		<i>Yes</i>	<i>Yes</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from <i>10.30.1965</i> to <i>11.6.1965</i> , that (I) (we) last saw the deceased alive on <i>11.6.1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE	M.D.	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED
<i>Dr. Boelner</i>					<i>11.7.1965</i>
23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
<i>Burial</i>	<i>11/11/65</i>	<i>Holy Redeemer Cem.</i>	<i>Baltimore, Md.</i>		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
<i>NOV 9 1965</i>	<i>Robert E. Talbot</i>	<i>Schimunek Funeral Home, Inc. 3331 Brehms Lane</i>			

RECEIVED

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11426	
BIRTH NO. 65 11426		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>DeLuca, Joseph M.</b>			2. DATE AND HOUR OF DEATH <b>11-8-65 9:40 a.m.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME + HOSPITAL</b> <b>BALTIMORE, MD. 21231</b>			A. STATE <b>MARYLAND</b> B. COUNTRY <b>USA</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 5300</b> D. STREET ADDRESS (If rural, give location) <b>2340 HAMILTOWNE CIRCLE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11-20-28</b>	9. AGE (In years lost birthday) <b>36</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Sinclair Refining Co</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			13. FATHER'S NAME <b>ABRAHAM DeLuca</b>		
14. MOTHER'S MAIDEN NAME <b>MARIA <del>DeLuca</del> Annunciato</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Army-Korean 212-26-1886</b>		
16. SOCIAL SECURITY NO. <b>212-26-1886</b>			17. INFORMANT ADDRESS <b>Joyce McLaughlin DeLuca, wife, above</b>		
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>few min. one day</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>○</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>—</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-8-65</b> to <b>11-8-65</b> , that (I) (we) last saw the deceased alive on <b>11-8-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Schwarano</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>11-8-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH C. MARIANO</b>				23D. ADDRESS <b>CHURCH HOME + HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/12/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	

Delaware, - 1951

MARYLAND

CHURCH HOME + HOSPITAL  
BALTIMORE, MD 21201

BALTIMORE  
3300 HANNAH STREET

MARYLAND

11-20-58

MARYLAND

ARMED DELAWARE

MARYLAND

CHURCH HOME  
BALTIMORE, MD

ARMED DELAWARE

ARMED DELAWARE

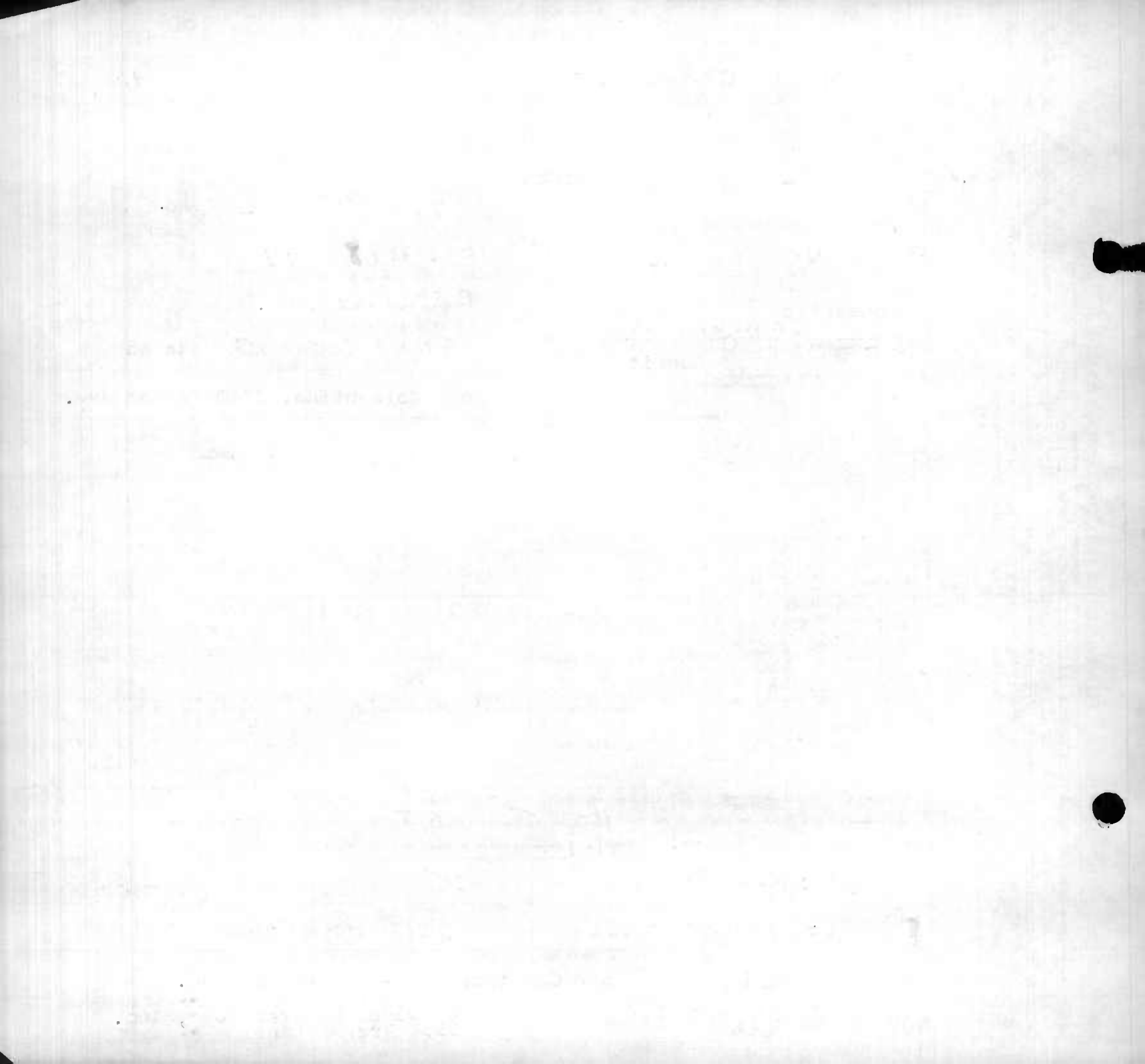
CHURCH HOME + HOSPITAL



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11427	
BIRTH NO. 65 11427		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARIE CORDELLA		2. DATE AND HOUR OF DEATH 11-6-65 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2740 Pelham Ave.		A. STATE Md. B. COUNTY 2701			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2740 Pelham Ave.			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W.	8. DATE OF BIRTH 10-2-1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME SUMMIT CORDELLA		14. MOTHER'S MAIDEN NAME ANNA SUMMIT		12. CITIZEN OF WHAT COUNTRY? American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS John Cossentino, 2740 Pelham Ave.	
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH BRONCHO PNEUMONIA			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		arteriosclerotic heart disease			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 11-15-1964 to 11-5-1965, that (I) (we) last saw the deceased alive on 11-5-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sebastian Russo		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-6-65	
23C. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO		23D. ADDRESS 5017 HARFORD Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/10/65		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
				24D. LOCATION (City, town, or county) Baltimore, Md. (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 9 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	



65 11428  
BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11428

M-236

1. NAME OF DECEASED (Type or Print) **ROBERT MIXTER**

2. DATE AND HOUR PRONOUNCED DEAD **11-6-65 9:05 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION **Union Memorial Hospital**  
ADDRESS OR LOCATION **2-28-66**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**  
D. STREET ADDRESS (If rural, give location) **1500 Burnwood Rd.**

5. SEX **male** 6. RACE **white** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH **May 8, 1923** 9. AGE (In years last birthday) **42** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Lieutenant** 10B. KIND OF BUSINESS OR INDUSTRY **Fire Department** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Harry E. Mixter** 14. MOTHER'S MAIDEN NAME **Edith N. Eccard**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **Yes WWII** 16. SOCIAL SECURITY NO. **219 16 3162** 17. INFORMANT **Dorothy J. Mixter** ADDRESS **1500 Burnwood Road**

18. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
**E 976 X + 3 22.0**  
(A) **Gunshot wound of head**  
DUE TO  
(B) **Acute Alcoholism**  
DUE TO  
(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **11-6-65** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **NO** 20A. AUTOPSY? (Yes or No) **NO** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **home** 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **home** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **1500 Burnwood Rd.**

21D. TIME OF INJURY (APPROX.) **11-6-65 5:45 P.M.** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **shot self in head**

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Normal causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Rudiger Breiteneker, M.D.** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **11-7-65**  
EXAMINER'S NAME (Type) **Rudiger Breiteneker, M.D.** ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **burial** 23B. DATE **10 Nov 65** 23C. NAME OF CEMETERY or CREMATORY **Moreland Memorial Park** 23D. LOCATION (City, town, or county) (State) **Taylor Ave, Baltimore Co., Md.**

24A. DATE REC'D BY HEALTH DEPT. **NOV 9 1965** 24B. NAME OF REGISTRAR **Robert E. Farley, M.D.** 24C. FUNERAL DIRECTOR **Burges Funeral Home, 3631 Falls Rd. Balto. Md.** By: **Harold W. Burges**

VALLEY FORCE

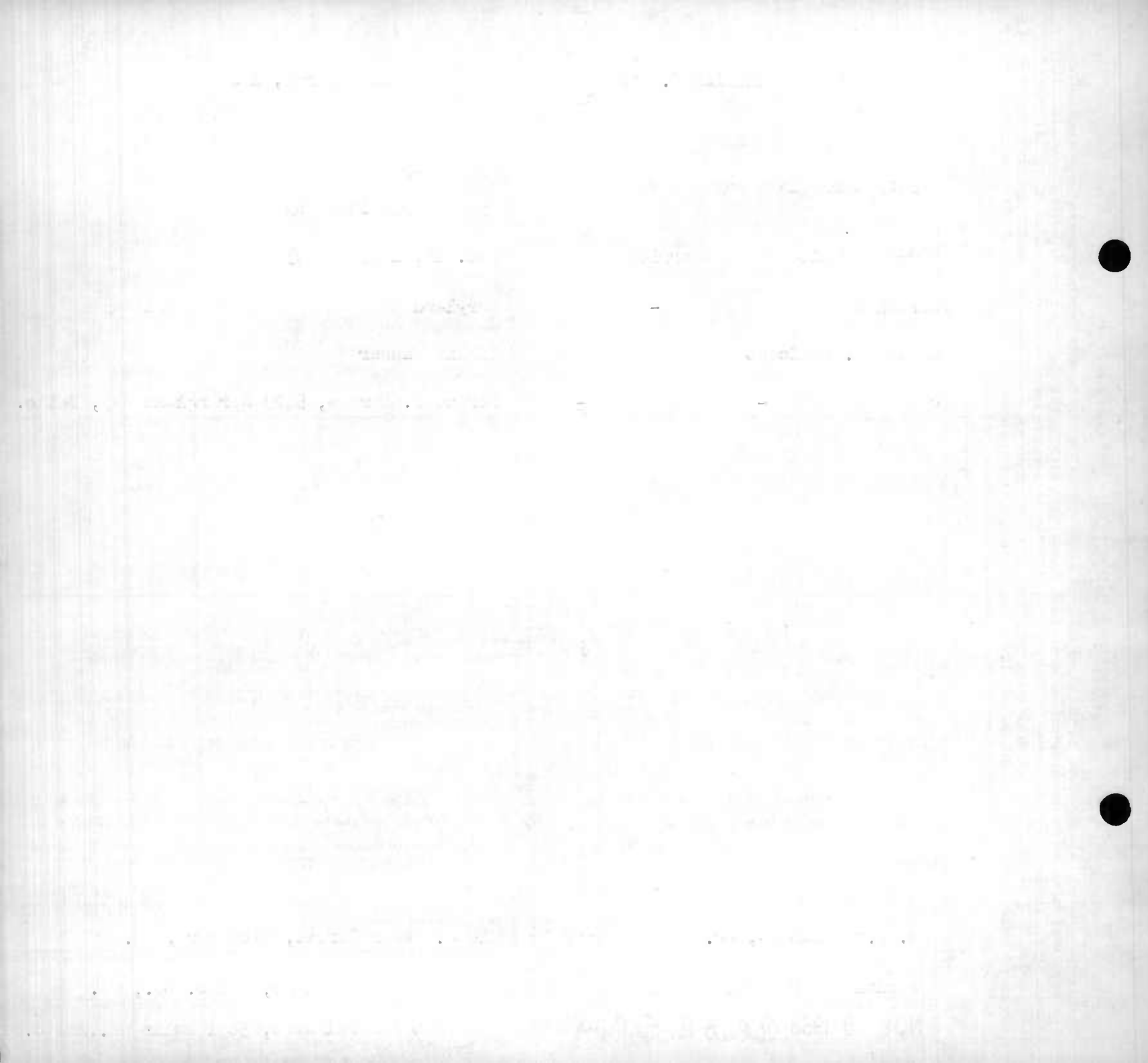
ALL CONTENT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 11429		M.E. CASE NO.		65 11429	
1. NAME OF DECEASED (Type or Print) <b>Lillian C. Burgee</b>			2. DATE AND HOUR OF DEATH <b>November 5, 1965</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5423 Springlake Way</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-12</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5423 Springlake Way</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 14, 1889</b>	9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William H. Chilcoat</b>			14. MOTHER'S MAIDEN NAME <b>Lillia Fisher</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT ADDRESS <b>Horace F. Burgee, 5423 Springlake Way, Balto.</b>		
18. <b>153.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Carcinoma of Colon</b> DUE TO (B) <b>with metastasis</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>arteriosclerosis c.v.d.</b>		<b>5 years</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>9/6</b> 19 <b>65</b> to <b>11/5</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>11/5</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. H. Townshend, Jr.</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>11/8/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. H. Townshend, Jr.</b>		23D. ADDRESS <b>14 E. Eager Street, Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9 Nov 65</b>	24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co., Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>	25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Burgee Funeral Home, 3631 Falls Rd., Balto. Md.</b>			

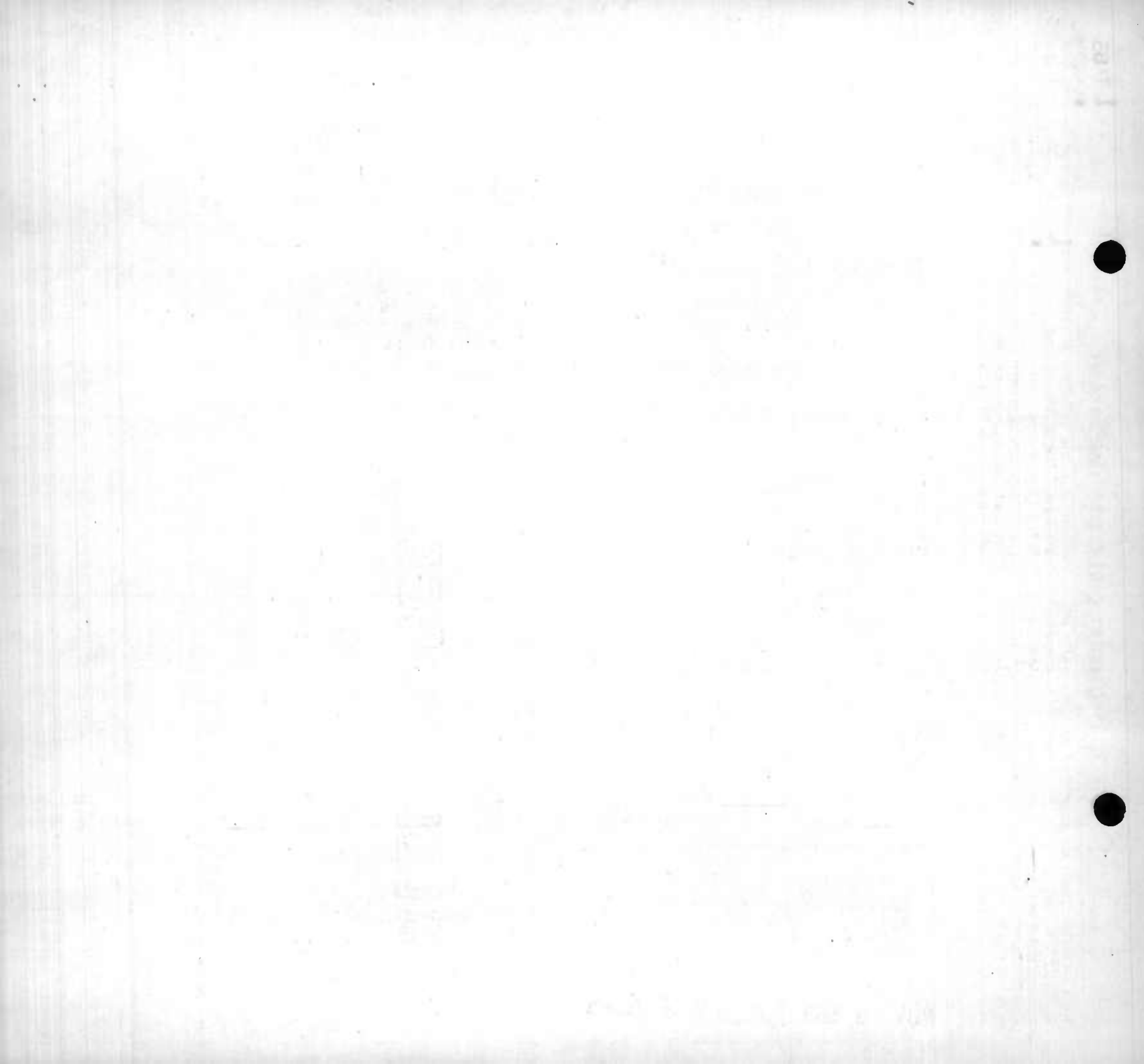


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11430		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11430	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>HARRY WOODEN</b>			2. DATE AND HOUR OF DEATH <b>11-7-65 10:25 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2926 HARFORD ROAD</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>3-5-82</b>	9. AGE (In years) lost <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sationary Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>WILLIAM</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
14. MOTHER'S MAIDEN NAME <b>MARY NEIL</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>216-05-5486</b>		17. INFORMANT <b>Katherine Myer</b> ADDRESS <b>4016 Vila Nova Road</b>			
18. <b>4221 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>cardio Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/3</b> <b>19 65</b> to <b>11/7</b> <b>1965</b> , that (I) (we) lost saw the deceased alive on <b>11/7</b> <b>19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lee J. Silver</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE, SIGNED <b>11/7/65</b>
23C. PHYSICIAN'S NAME (Type) <b>Lee J. Silver</b>			23D. ADDRESS <b>Johns Hopkins Hospital Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Nov 10, 1965</b>	24C. NAME of CEMETERY or CREMATORY <b>St. Marys (Hampden)</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Frank A. Seitz</b> ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11431		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11431	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Delus Glenn Roberts		2. DATE AND HOUR OF DEATH Nov. 3, 1965 3: 55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Park Dr. & 31st Street		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Md. B. COUNTY Upper Marlboro C. CITY OR TOWN (If outside city limits, write RURAL and give township) 66-00 D. STREET ADDRESS (If rural, give location) 3606 Oxford Court, Route 2			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/9/17	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Excavator		10B. KIND OF BUSINESS OR INDUSTRY Contracting		11. BIRTHPLACE (State or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel E. Roberts		14. MOTHER'S MAIDEN NAME Maude Wyatt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1941-1945		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. 204.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema & Uremia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myelogenous leukemia		CAUSE OF DEATH (A) <del>XXXXX</del> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Hours Days Months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Oct. 25 1965 to Nov. 3 19 65, that (1) (we) last saw the deceased alive on Nov. 3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James M. Weaver		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/4/65	
23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director		23D. ADDRESS M.D. US Public Health Service Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-transit		24B. DATE 11/7/65		24C. NAME of CEMETERY or CREMATORY Memorial Gardens	
24D. LOCATION (City, town, or county) (State) Union City, Tenn.					
25A. DATE REC'D BY HEALTH DEPT. NOV 9 1965		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR ADDRESS Ritchie Brothers, Upper Marlboro, Md.	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 11432		<b>CERTIFICATE OF DEATH</b>		65 11432	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Aiken</i>		(DONALD J. AIKEN) <i>Donald</i>		2. DATE AND HOUR OF DEATH <i>11/13/65</i> <i>10 35 P</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 Mercy Hosp</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Anne Arundel</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glenn Burnie</i> <i>52-00</i> D. STREET ADDRESS (If rural, give location) <i>Rt 1 Bx 304E</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>7/27/86</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Robert Aiken</i>			14. MOTHER'S MAIDEN NAME <i>Lucie Johnson</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Laura Aiken &amp; Hospt. Records</i>		
18. <i>527.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Anemia, Undetermined et al</i>			CAUSE OF DEATH (A) <i>Chronic Obstr. Airway Dis.</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>18 years</i>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>11/2/65</i> 19 to <i>11/13/65</i> 19, that (we) last saw the deceased alive on <i>11/13/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Chester C Collins Jr MD</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>11/13/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Chester C Collins Jr</i> M.D.				23D. ADDRESS <i>Mercy Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <i>11/8/65</i>	24C. NAME of CEMETERY or CREMATORY <b>CATHEDRAL CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <b>WIEDEFELD &amp; SON-501 E. 22ND</b>	

Mr. J. H. H. H.

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <b>65 11433</b>	
BIRTH NO. <b>65 11433</b>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Joseph C. Gricoskie</b>		2. DATE AND HOUR OF DEATH <b>11-4-65 2:25 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>(JOSEPH CHAS. GRICOSKIE)</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #21218</b> D. STREET ADDRESS (If rural, give location) <b>824 Argonne Drive.</b>			
5. SEX <b>M.</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>sep.</b>	8. DATE OF BIRTH <b>4-2-02</b>	9. AGE in years (last birthday) <b>63.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired.</b>		11. BIRTHPLACE (State or foreign country) <b>Po.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Gricoskie</b>				14. MOTHER'S MAIDEN NAME <b>Mary Suychanayc</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Hospt. Records SBGH</b>			
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Arteriosclerotic Cardio-</b> DUE TO (B) <b>Vascular Disease</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>10-14</b> 19 <b>65</b> to <b>11-4</b> 19 <b>65</b> , that <del>we</del> (we) last saw the deceased alive on <b>11-4</b> 19 <b>65</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Calvin E. Jones, Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-4-65</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/8/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Co</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME of REGISTRAR <b>Robert E. Faulkner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>WIEDEFELD &amp; SON-GREENMOUNT &amp; 22ND</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11434				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11434	
1. NAME OF DECEASED (Type or Print) <b>ATKINSON, DOCK</b>				2. DATE AND HOUR OF DEATH <b>NOV. 7, 1965 10:00 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>FRANKLIN SQUARE HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>PASADENA</b>					
				D. STREET ADDRESS (If rural, give location) <b>RT. #1 BOX 105 PASADENA</b>					
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED-NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8/30/1900</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MARINE ENGINEER M.E.B.A. - Dist #1</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN ATKINSON</b>				14. MOTHER'S MAIDEN NAME <b>SALLY GIBSON</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-028933</b>		17. INFORMANT <b>VICTORIA ATKINSON</b>		ADDRESS <b>SAME</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>180X I</b>				CAUSE OF DEATH (A) <b>Recurrent adenocarcinoma</b> DUE TO (B) <b>of Right kidney with</b> DUE TO (C) <b>carcinomatosis.</b>				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>11-4-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CHOLECYSTITIS WITH CHOLELITHIASIS</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10-25</b> 19 <b>65</b> to <b>11-7</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>11-7</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Emmanuel M. Maniago</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-7-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>EMMANUEL M. MANIAGO M.D.</b>				23D. ADDRESS <b>FRANKLIN SQ. HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov. 10/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fadden</b>		25C. FUNERAL DIRECTOR ADDRESS <b>P.V. Singleton, Glen Burnie, Md.</b>					

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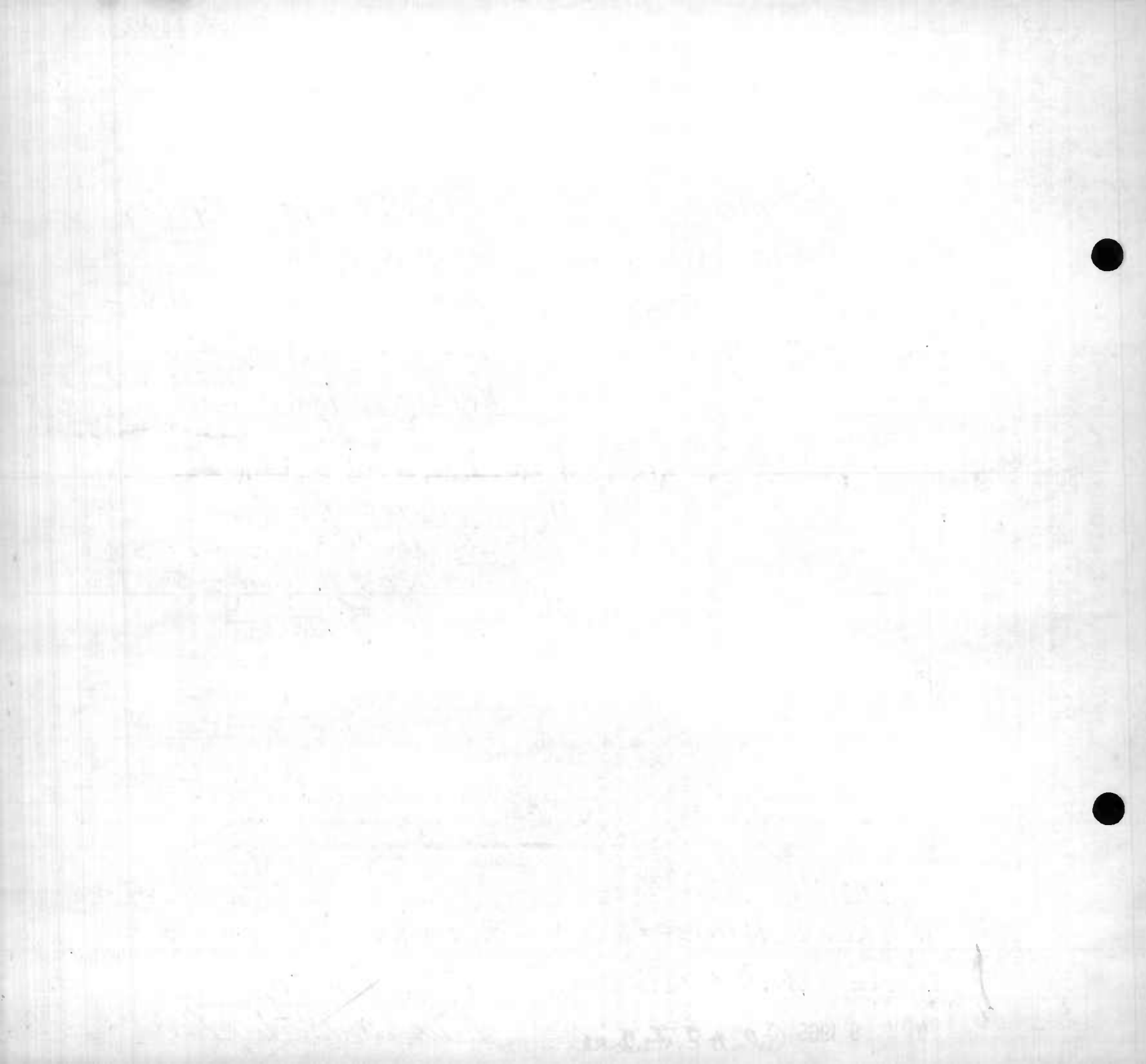
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11435	
BIRTH NO. 65 11435		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EMMA ELIZABETH GRUBE</b>		2. DATE AND HOUR OF DEATH <b>Nov. 4, 1965</b> 11:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>12-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>307 E. UNIVERSITY PKY. BALTO, MD</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. MD.</b>			
		D. STREET ADDRESS (If rural, give location) <b>307 E. UNIVERSITY PKY.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>OCT. 18, 1875</b>	9. AGE (In years last birthday) <b>90</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES B. HOLLIS</b>		14. MOTHER'S MAIDEN NAME <b>LAURA U. GRIFFIN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MRS CARLINE ABBOTT</b> ADDRESS - <b>1653 SHADYSIDE RD. BALTO MD. 21218</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Rheumatoid Arthritis</b>		CAUSE OF DEATH <b>Bleeding Duodenal ulcer</b> (A) <b>Hemorrhage + Shock</b> DUE TO <b>arteriosclerotic Heart Disease</b> DUE TO <b>Hypertensive Cardiovascular Disease</b> (C) <b>generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>—</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1958</b> to <b>Nov 4, 1965</b> , that (I) (we) last saw the deceased alive on <b>Nov 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald W. Minter</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/6/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DONALD W. MINTER</b>		23D. ADDRESS M.D. <b>3009 EVERGREEN AVE. BALTO, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>NOV 8, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>GREENMOUNT CEM. BALTO, MD</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO, MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>R. Madison Mitchell</b>		ADDRESS <b>Harvard Cray, MD</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City and County Health Department																													
BIRTH NO. <i>Culvert Co., Md.</i>					CERTIFICATE OF DEATH					Registered No. <i>65 11436</i>																			
M.E. CASE NO. <i>65 11436</i>					1. NAME OF DECEASED (Type or Print) <i>Jonathan Black</i>					2. DATE AND HOUR OF DEATH <i>Nov 5, 1965 1245 P.M.</i>																			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					A. STATE <i>MD.</i> COUNTY <i>Calvert</i>																			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>UNIVERSITY HOSP.</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>PRINCE FREDERICK 1754-00</i>					D. STREET ADDRESS (If rural, give location) <i>Dares Beach -</i>																			
5. SEX <i>M</i>		6. RACE <i>W.</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M. MARR</i>		8. DATE OF BIRTH <i>Oct 31, 65</i>		9. AGE (In years last birthday) <i>-</i>		If Under 1 Yr. Months: <i>5</i> Days: <i>5</i> Hours: <i>-</i> Min.		If Under 24 Hrs. Min.																	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>					11. BIRTHPLACE (State or foreign country) <i>MD.</i>					12. CITIZEN OF WHAT COUNTRY? <i>US</i>														
13. FATHER'S NAME <i>RONALD BLACK.</i>					14. MOTHER'S MAIDEN NAME <i>RAMONA PHILLIPS</i>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>					16. SOCIAL SECURITY NO. <i>-</i>					17. INFORMANT <i>Ronald Black</i> ADDRESS <i>(above)</i>									
18. <i>763.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) <i>PNEUMONIA</i> DUE TO (B) <i>-</i> DUE TO (C) <i>-</i>					INTERVAL BETWEEN ONSET AND DEATH <i>48 HOURS</i>																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CONGENITAL HEART DISEASE</i>					19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>					20A. AUTOPSY? (Yes or No) <i>-</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>-</i>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? <i>-</i>				
22. I certify that (I) <i>this hospital</i> attended the deceased from <i>NOV 3</i> 19 <i>65</i> to <i>NOV 5</i> 19 <i>65</i> , that (I) <i>we</i> last saw the deceased alive on <i>NOV 5</i> 19 <i>65</i> and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did) (did not) view the body after death.																													
23A. SIGNATURE <i>Erney Maher</i> M.D.										Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>5 NOV 65</i>														
23C. PHYSICIAN'S NAME (Type) <i>ERNEY MAHER</i> M.D.										23D. ADDRESS <i>University Hospital</i>																			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>Nov 7 1965</i>					24C. NAME OF CEMETERY OR CREMATORY <i>Wesley Cemetery</i>					24D. LOCATION (City, town, or county) (State) <i>Prince Frederick, Calvert, Md.</i>														
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 9 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Farber, MA</i>					25C. FUNERAL DIRECTOR <i>A.P. HARRIS &amp; Son</i>					ADDRESS <i>Northgate, Md.</i>														

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 11437	
BIRTH NO. 65 11437		CERTIFICATE OF DEATH			
M.E. CASE NO. 45-02-75					
1. NAME OF DECEASED (Type or Print) Weaver, Lennie		2. DATE AND HOUR OF DEATH 11/8/65		12. CITIZEN OF WHAT COUNTRY? U.S.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Balto. md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 9-07	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BCH Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland		D. STREET ADDRESS (If rural, give location) 2643 Kirk Ave.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) divorced	8. DATE OF BIRTH 9-15-92	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child care		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Whitestone, VA.	
13. FATHER'S NAME James Weaver		14. MOTHER'S MAIDEN NAME Lucy Braxton		17. INFORMANT JAMES WARD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. 443X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Cardiac Arrhythmia			
ANTECEDENT CAUSES		(B) DUE TO CHF & Anasarca			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) -			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-23-1965 to 11-8-1965, that (I) (we) last saw the deceased alive on 11-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Richmon		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/8/65	
23C. PHYSICIAN'S NAME (Type) J. Richmon		23D. ADDRESS BCH 4940 Eastern Avenue			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11/11/65		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
24D. LOCATION A.A. County Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 9 1965		24F. NAME OF REGISTRAR Robert E. Fink	
24G. FUNERAL DIRECTOR Milton E. Elickson		24H. ADDRESS 2971 Caroline St			



JAMES WALKER

NO

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 1.5em;">65 11438</span>	
1. NAME OF DECEASED (Type or Print) <b>William A. Reed</b>			2. DATE AND HOUR OF DEATH <b>Nov. 7, 1965</b> <span style="float: right;"><b>8:30 a.m.</b></span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>KESWICK Home 700 West 40th Street</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>28-22</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4502 Wentworth Road 21207</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAY 6, 1892</b>	9. AGE (in years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF-EMP. BUSINESSMAN</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Landscape Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>ARKANSAS</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>CHARLES L. REED</b>		
14. MOTHER'S MAIDEN NAME <b>LULU WARD</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>723-69-0255</b>			17. INFORMANT <b>KESWICK HOME RECORDS - E. Merrick - R.N.</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Myocardial Infarction 10 years</b>			19. CAUSE OF DEATH (A) DUE TO <b>Arteriosclerosis (generalized) 10 years</b> (B) DUE TO (C)		
19A. DATE OF OPERATION <b>11/7/65</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Myocardial Infarction</b>		
20A. AUTOPSY? (Yes or No) <b>No</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>May 6, 1965</b> to <b>November 7, 1965</b> , that (I) (we) last saw the deceased alive on <b>November 6, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Grafton Hersperger</b>			23B. DATE SIGNED <b>11/7/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>W. Grafton Hersperger</b>			23D. ADDRESS <b>700 W. 40th Street</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/10/1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION <b>Woodlawn, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>			
24F. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24G. FUNERAL DIRECTOR <b>Wm. F. Tichner &amp; Sons</b>			
24H. ADDRESS <b>Baltimore, Md. 17</b>		24I. ADDRESS <b>Baltimore, Md. 17</b>			



65 11439

BALTIMORE CITY HEALTH DEPARTMENT

65 11439

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EDNA BROWN (SMITH)

2. DATE AND HOUR PRONOUNCED DEAD

11-6-65

8:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2826 Walbrook Ave.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

Nov. 20, 1903

9. AGE (In years  
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harvey Whyte

14. MOTHER'S MAIDEN NAME

Edna

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Chlorice Sue Ware - 34-7 Powhattan Ave.

18.

E 902.01 + 322.0  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH(A) Multiple traumatic injuries  
DUE TO

(B) DUE TO

(C) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

Acute ethylism

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

house

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

2844 Walbrook Ave.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

11-6-65

?

m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Apparently fell from height

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-7-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-10-65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

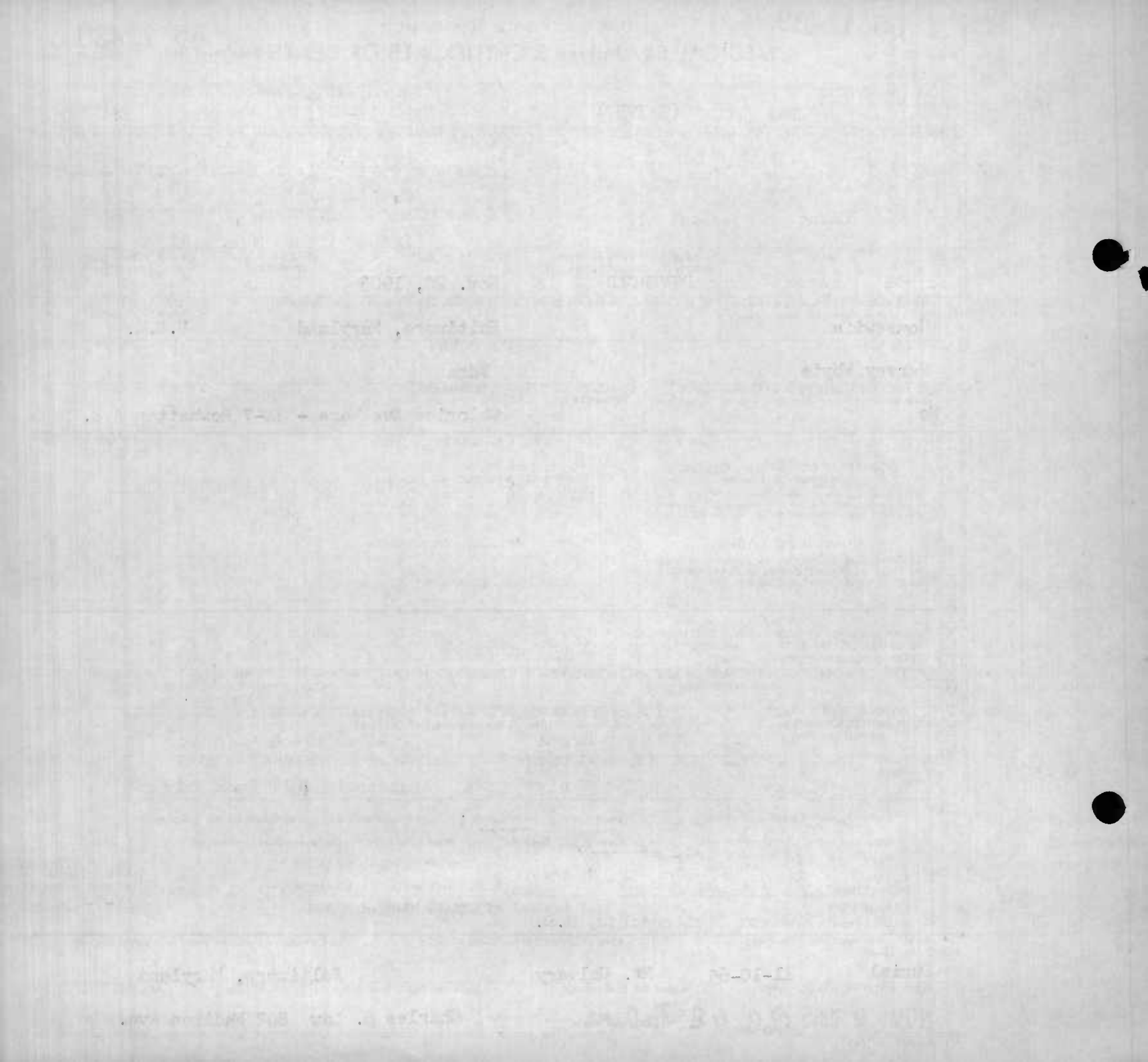
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 9 1965 Robert E. Finkbeiner

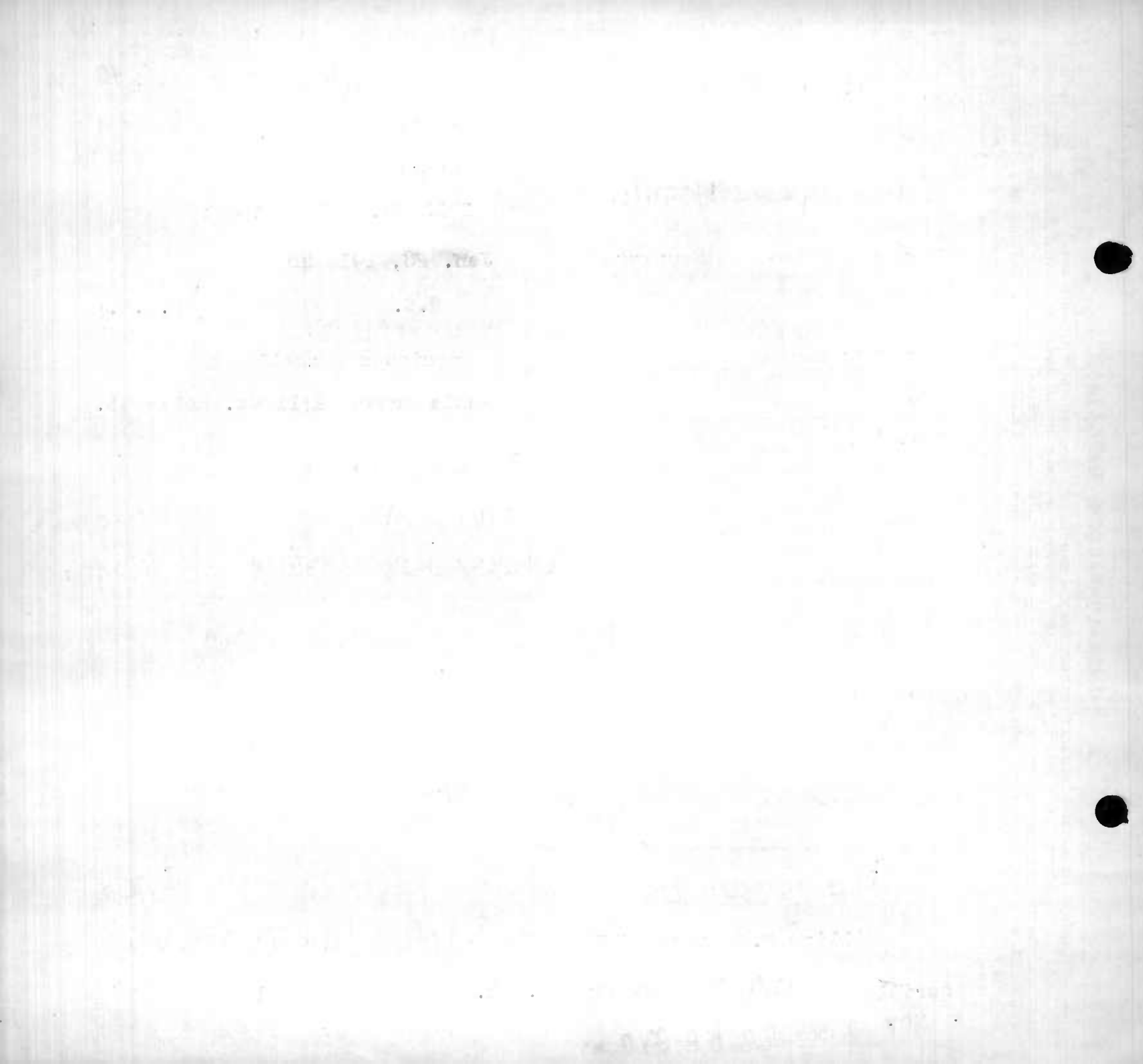
Charles R. Law 802 Madison Ave.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11440	
BIRTH NO. 65 11440		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Alice Macon</b>		2. DATE AND HOUR OF DEATH <b>11/8/65</b> <b>840</b> <b>A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-09</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>2711 Mt. Holly Street</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>Jan. 28, 1917</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Grant MacLease</b>			14. MOTHER'S MAIDEN NAME <b>Narcissus Hussell</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Annie Brown 2711 Mt. Holly St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>392X+1170X</b> (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>Cardiac Arrest</b> DUE TO (B) <b>UREMIA</b> DUE TO (C) <b>Chronic Renal Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>10 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Porphyrria, Breast Carcinoma</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>at</del> (this hospital) attended the deceased from <b>9/22</b> <b>19 65</b> to <b>11/8</b> <b>19 65</b> , that <del>at</del> (we) last saw the deceased alive on <b>11/8</b> <b>19 65</b> and that in <del>at</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>at</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W.H. Spencer III</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/8/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>William H. Spencer III</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/12/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George A. Kilar 1348 N. Calhoun St.</b>	



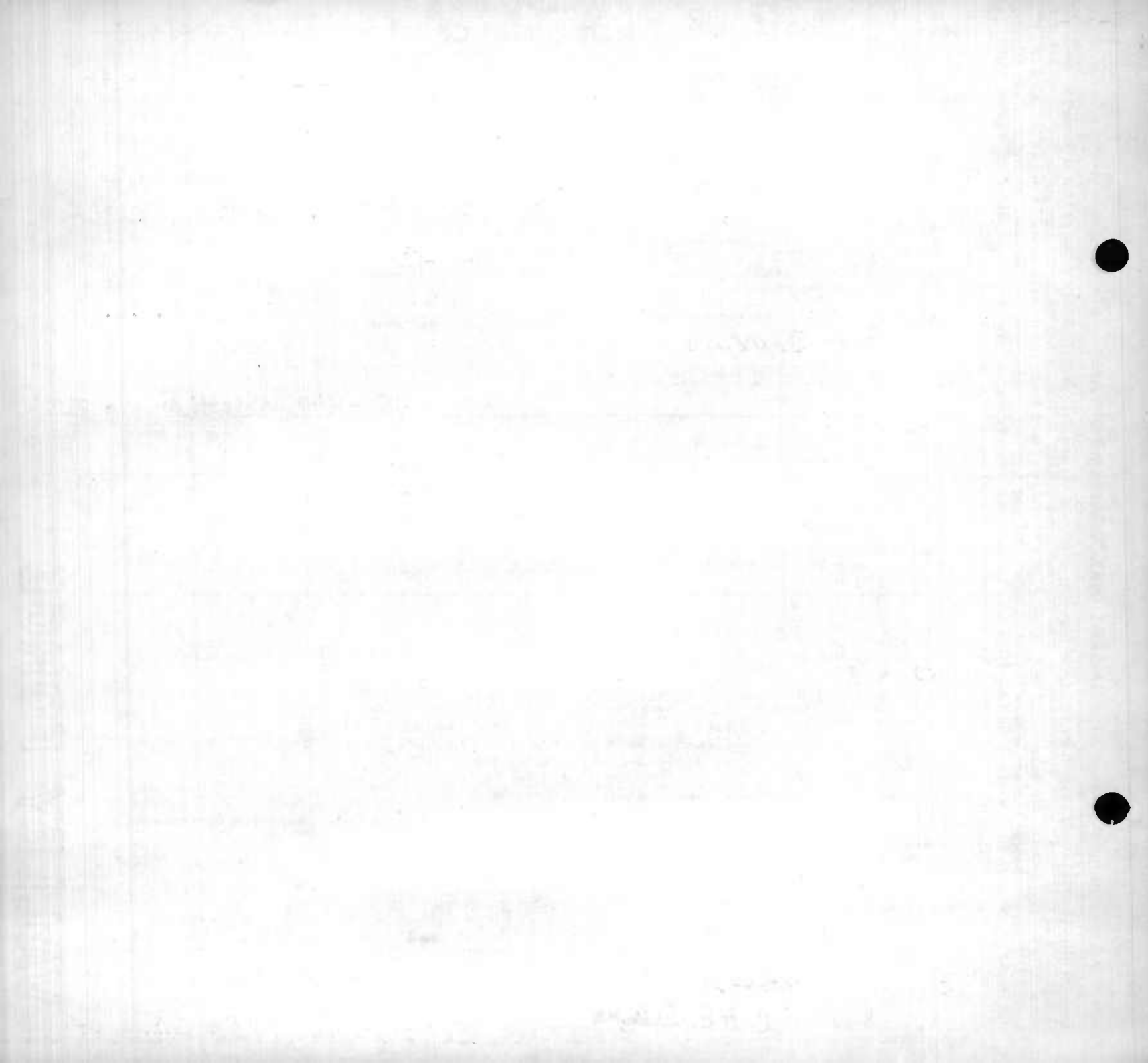


65 11441		BALTIMORE CITY HEALTH DEPARTMENT		65 11441	
BIRTH NO. 65-6705		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		MARION WATERS		11-7-65 7:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  PROVIDENT HOSPITAL - DOA		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1711 McCulloh Street 21217			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH March 14, 1965	9. AGE (in years last birthday) 8 mos	If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Malcar Waters		14. MOTHER'S MAIDEN NAME Mildred Ellis		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MIXX Mildred Ellis 1711 McCulloh St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute interstitial pneumonitis DUE TO INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
(Month) (Day) (Year) (Hour)		WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22.		I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		11/10/65		Mt Auburn Cem.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
NOV 9 1965		Robert E. Farley, M.D.		George H. Kuhn 1348 N. Calhoun St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 14781-65 11442		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11442	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Betty Jenkins		11-7-1965 1:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland		12-0-01	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		412 East 20th. Street 21218	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Negro	Never Married	5-21-61	4	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Jimmy Jenkins		Serie		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0 NA	NA	No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
NA	WA	UA			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
WA	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	WA			
22. I certify that (I) (this hospital) attended the deceased from NOV 3 19 65 to NOV 7 19 65, that (I) (we) last saw the deceased alive on NOV 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Jose Aguto				NOV 7 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Jose Aguto		Maryland 4940 Eastern Avenue, Baltimore,			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	11-14-65	Church Cem.	Rocky Mount, N.C.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
NOV 9 1965	Robert E. Farley, MA	George L. Kels 1348 N. Calhoun St			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11443		CERTIFICATE OF DEATH		Registered No. 65 11443	
1. NAME OF DECEASED (Type or Print) <b>WILLIE CLARK</b>				2. DATE AND HOUR OF DEATH <b>Nov. 2, 1965 8:05 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 16-06</b> D. STREET ADDRESS (If rural, give location) <b>910 FRANKLINTOWN RD.</b>					
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>7-19-1911</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Jackson Clark</b>				14. MOTHER'S MAIDEN NAME <b>Marie Dingle</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue, 21224</b>			
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>CARCINOMA OF COLON</b> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 4 wks.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10/5/65</b> to <b>11/2</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>11/1</b> 19 <b>65</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Barry Wayne Uhr</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/2/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>BARRY WAYNE UHR</b>				23D. ADDRESS M.D. <b>BALTIMORE CITY HOSPITALS</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/6/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Alburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Isaiah L. Brown 108W. Montgomery st</b>			

SECRET

65 11444

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 11444

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ISIAH SMALL (Isaiah)

2. DATE AND HOUR PRONOUNCED DEAD

November 2, 1965

1:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

23-01  
906 Peach Street

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

3-26-1907

9. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JOHN SMALL

14. MOTHER'S MAIDEN NAME

JULIA ST. JOHN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

FLORA DODD 925 Joplen

18. 161X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cancer of the larynx with metastases  
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/8/65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 9 1965

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Isaiah L. Brown &amp; Son

108 W. Montgomery St.

ADDRESS



100-100-1

100-100-1

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11445	
BIRTH NO. 65 11445		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>John Watson</i>		2. DATE AND HOUR OF DEATH <i>10-30-65 4:55 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp</i>		A. STATE <i>Maryland</i> B. COUNTY <i>22-01</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> # <i>21230</i>			
		D. STREET ADDRESS (If rural, give location) <i>111 W. Basse St.</i>			
5. SEX <i>M.</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWER</i>	8. DATE OF BIRTH	9. AGE (In years last birthday) <i>95</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11. BIRTHPLACE (State or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <i>Martha</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Louise Taylor</i>		ADDRESS <i>111 W Basse St</i>
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic Cardiovascular Disease</i>		CAUSE OF DEATH <i>Arteriosclerotic Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <i>10-10-65</i> to <i>10-26-65</i> , that <del>the</del> (we) last saw the deceased alive on <i>10-26-65</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kenneth P. Bonovich</i>				23B. DATE SIGNED <i>10-30-65</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>South Balto. Gen. Hosp.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/3/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 9 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Isaiah L. Brown &amp; son</i>			
25D. ADDRESS <i>108 W. Mont.</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <b>65 11446</b>	
BIRTH NO. <b>65 11446</b>				1. NAME OF DECEASED (Type or Print) <b>Martin Amos Stephens</b>		2. DATE AND HOUR OF DEATH <b>11/8/65 1:50 p.m.</b>	
<div style="font-size: 2em; font-weight: bold;">CERTIFICATE AMENDED</div> <div style="font-size: 1.5em;">FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b></div> <div style="font-size: 1.5em;">(If not in hospital or institution, give street address or location) <b>11-22-65 11-26-65</b></div>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
5. SEX <b>male</b>				6. RACE <b>Caucasian</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SALESMAN</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>LUMBER</b>		8. DATE OF BIRTH <b>10/7/80</b>	
13. FATHER'S NAME <b>Jeremiah Stephens</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jones</b>		9. AGE (In years last birthday) <b>85</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-01-1803</b>		17. INFORMANT (wife) <b>Grace O. Stephens</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>617X1</b>				CAUSE OF DEATH		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <b>GANGRENE SCROTUM</b> DUE TO (B) <b>ACUTE MYOCARDIAL INF.</b> DUE TO (C) <b>SEPTICEMIA</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>17 NOV 1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene Scrotum</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7/11/65</b> 19 to <b>8/11/65</b> 19, that (I) (we) lost saw the deceased alive on <b>8/11/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard R. Stephenson</b>				M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/11/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD R. STEPHENSON</b>				23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/11/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Churchville Presbyterian Yard</b>		24D. LOCATION (City, town, or county) (State) <b>Churchville, Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>	

V.S. 153

11-26-65

Collected by V S 153

11-22-65 RHH

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 11447</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 11447</b>	
M.E. CASE NO. <b>C.</b> 1. NAME OF DECEASED (Type or Print) <b>MELVIN G. SEIBERT</b>			2. DATE AND HOUR OF DEATH <b>4 November 1965 6:35 P</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>11-22-65</b> <b>46 Lutheran Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Rosedale 53-00</b> D. STREET ADDRESS (If rural, give location) <b>7722 Philadelphia Rd.</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>15 October, 1908</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Adam Seibert</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Sept. 43- Dec. 45</b>		16. SOCIAL SECURITY NO. <b>215-095991</b>		17. INFORMANT <b>Mrs. Florence Seibert, 7722 Philadelphia Rd.</b>	
18. <b>420.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Angina Pectoris</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Angina Pectoris</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 20 1965</b> to <b>Nov 4 1965</b> , that (I) (we) last saw the deceased alive on <b>Nov 3 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louis A. M. Krause</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>Nov 8, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis A. M. Krause,</b> M.D.			23D. ADDRESS <b>11 E. Chase St.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>11-8-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Ulrich Funeral Home, Baltimore, Md.</b>	

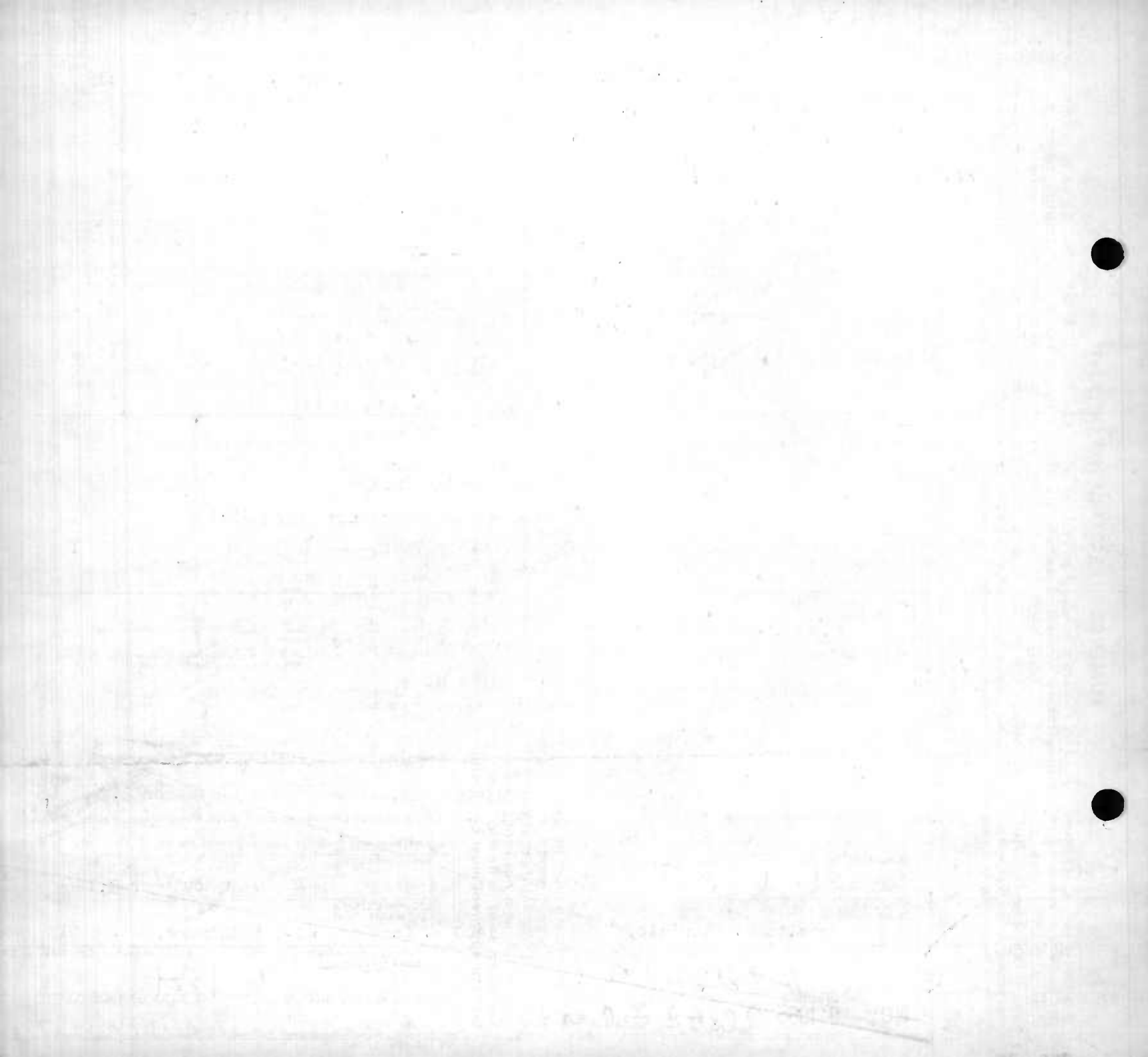




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11448</b>	
BIRTH NO. <b>65 11448</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JONES, ROBERT</b>		2. DATE AND HOUR OF DEATH <b>November 3, 1965 5:15 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>St. Joseph Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>8-07</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21213</b> D. STREET ADDRESS (If rural, give location) <b>1101 N. Broadway</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>4-11-19</b>	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Sabon</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Mingo Jones</b>			14. MOTHER'S MAIDEN NAME <b>Pathe Perkins</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>092-092572</b>	17. INFORMANT <b>Family</b>		ADDRESS
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Congestive heart failure myocardial infarction</b> DUE TO (B) <b>Severe depression and malnutrition</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 21, 1965</b> to <b>November 3, 1965</b> , that (I) (we) last saw the deceased alive on <b>November 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Gracito V. Patricio</b> M.D.				23B. DATE SIGNED <b>November 3, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Gracito V. Patricio,</b>		23D. ADDRESS <b>1400 N. Caroline St., Baltimore, Md. 21213</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/9/65</b>	24C. NAME of CEMETERY or CREMATORY <b>Int Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Calverton, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Robert E. Williams</b> ADDRESS <b>1701 N. Bond St</b>	



BIRTH NO.

65 11449

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARY L. WRIGHT

2. DATE AND HOUR PRONOUNCED DEAD

November 5, 1965 11:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2007 E. Lafayette Street AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2007 E. Lafayette Street AVE.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

James Batley

14. MOTHER'S MAIDEN NAME

Sattie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Family 2007 E. Lafayette Ave

18. 420.01

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/5/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALTER HOPKINS

PAID FOR TENDR

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 11450		BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No. 65 11450	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Elizabeth Johnson</i>		2. DATE AND HOUR OF DEATH <i>11-5-65 8:40 AM</i>		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>1314 N. Bentallou St.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>16-05</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO</i>		D. STREET ADDRESS (If rural, give location) <i>1314 N. Bentallou St.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>D.O.A. Lutheran Hosp.</i>		5. SEX <i>F</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>5-28-07</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Robert Calhoun</i>		14. MOTHER'S MAIDEN NAME <i>Hattie White</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wallace Johnson</i>	
18. <i>443X1</i>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary Embolism</i>		CAUSE OF DEATH (A) DUE TO <i>Hypertensive CARDIO-vascular DISEASE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Extreme Obesity</i>		(B) DUE TO		(C)			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Sept.</i> 19 <i>61</i> to <i>Nov.</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Oct.</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>James F. Cooper</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>11-5-65</i>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/10/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Ashtutue Mem. Pk.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wilmington Phillips</i>		ADDRESS <i>1727 N. Monmouth</i>	

the first part  
of the first  
volume

Vol. 1



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11451				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11451	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Bagwell, Bertha Louise</b>				2. DATE AND HOUR OF DEATH <b>4 Nov. 65 1 00 P.M.</b>			
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 University Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>2216 Mc Connel</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>unwed</b>	8. DATE OF BIRTH <b>4-2-00</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>John Holzworth</b>			14. MOTHER'S MAIDEN NAME <b>Barbara Edder</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>John Bagwell</b>		ADDRESS <b>701 W. Mulberry St.</b>
18. <b>199.2.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>				CAUSE OF DEATH (A) <b>Pneumonia</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Severe debilitate</b>				(B) <b>Severe debilitate</b> DUE TO			
				(C) <b>Carinomatosis</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1st 1965</b> to <b>Nov. 4th 1965</b> , that (I) (we) last saw the deceased alive on <b>Nov. 4th 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard P. Norgaard</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4 Nov. 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD P. NORGAAARD</b>				23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/8/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wilmington &amp; Shady 1727 N. Monroa</b>		ADDRESS	



James C. Gault, Esq.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

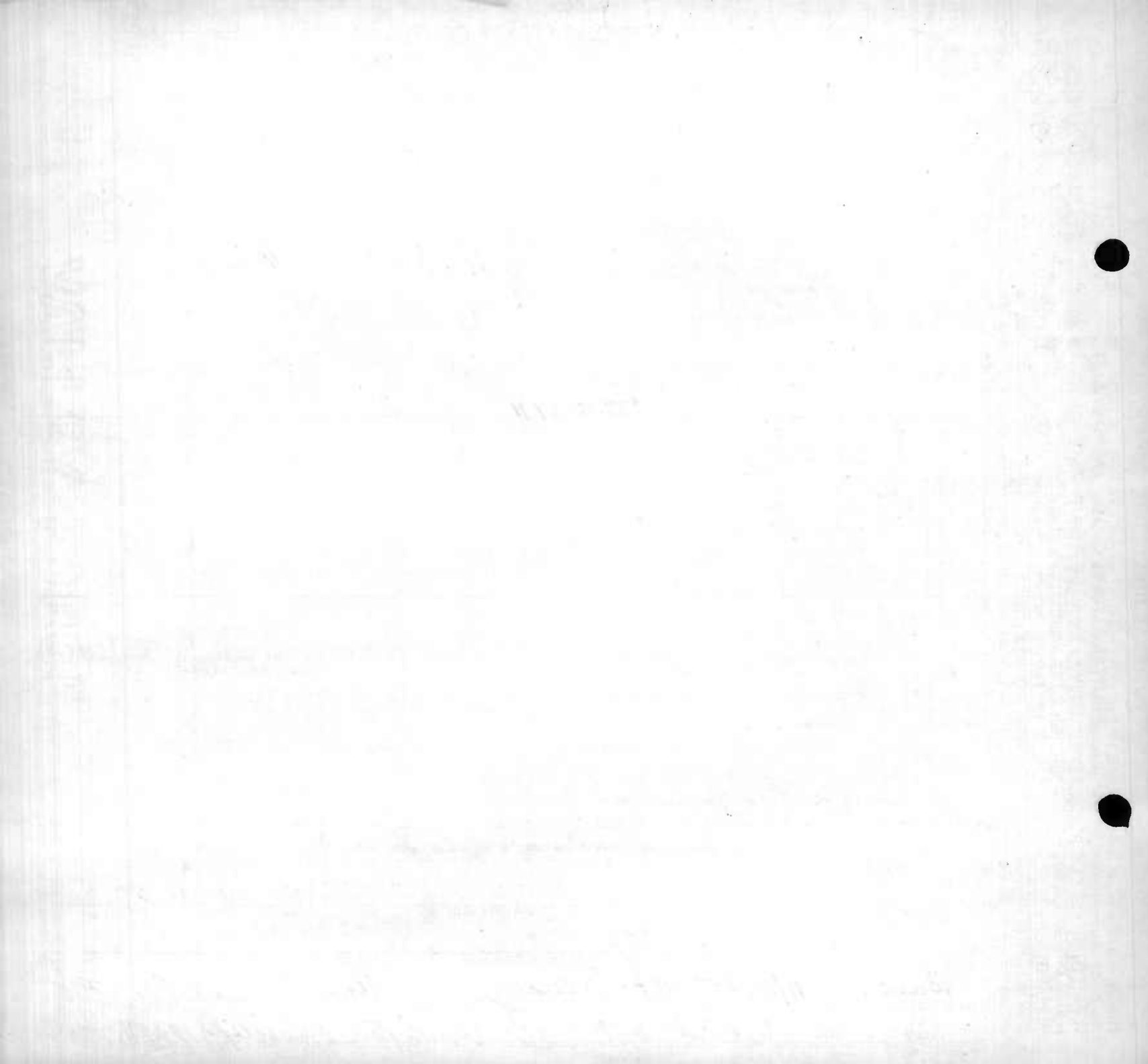
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11452	
BIRTH NO. 65 11452		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Emma Brown		2. DATE AND HOUR OF DEATH November 4, 1965 4:20 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY Baltimore			
1610 Bruce Court Baltimore, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1610 Bruce Court			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 4/13/1899	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland Co. Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Dorsey		14. MOTHER'S MAIDEN NAME Sarah			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-16 5642	17. INFORMANT Martha Parker		ADDRESS Same
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Hypertensive Cardiovascular Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/4 1965 to 11/4 1965, that (I) (we) last saw the deceased alive on 11/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph W. Reckling M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 11/5/65	
23C. PHYSICIAN'S NAME (Type) Ralph W. Reckling		23D. ADDRESS 420 N. Gilman Street Baltimore, Md.			
24A. BURIAL CREMATION REMOVAL (Specify) Burial	24B. DATE 11/8/65	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 9 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Addressington Phillips 1727 N. Morse St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

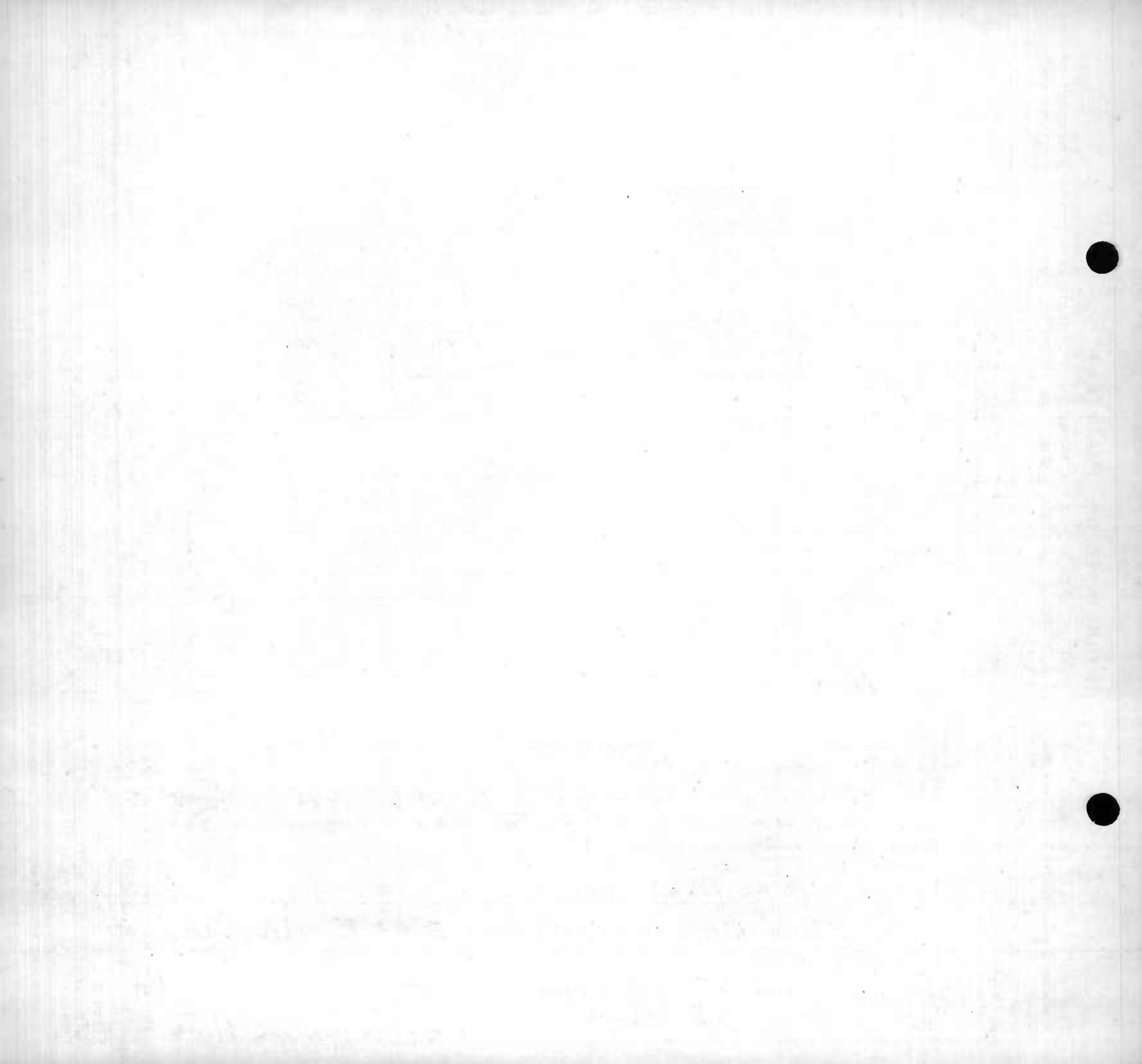
BIRTH NO. 65 11453		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11453	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) James Howard		
2. DATE AND HOUR OF DEATH 11/3/65 10 50 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital			A. STATE Maryland B. COUNTY Baltimore city		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 115 W. Pine St #1		
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	B. DATE OF BIRTH 11/7/1903	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY self employed	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hamp Howard			14. MOTHER'S MAIDEN NAME Annie Bennett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 237-18-2771	17. INFORMANT Mattie Howard	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.11 + 260X			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)			(A) Myocardial infarction		
ANTECEDENT CAUSES			(B) Arteriosclerotic Cardiovascular Disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Hypertensive Cardiovascular Disease		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Probable latent Diabetes mellitus					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 19 to 19, that (we) last saw the deceased alive on 11/3 19 65 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE William C. Wimmer			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/3/65
23C. PHYSICIAN'S NAME (Type) William C. Wimmer			23D. ADDRESS University of Md. Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION (City, town, or county) Anne Arundel Co. Md.		24E. (Staffs)			
25A. DATE REC'D BY HEALTH DEPT. NOV 9 1965		25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR Address 1727 N. Mount St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 11454	
BIRTH NO. 65 11454		CERTIFICATE OF DEATH		Registered No. 65 11454	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARY ETTA WISE		2. DATE AND HOUR OF DEATH Nov 5/65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 16-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 717 N. Carey St Balto 17 Md		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto			
		D. STREET ADDRESS (If rural, give location) 717 N Carey			
5. SEX F.	6. RACE colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widow	8. DATE OF BIRTH 9/16/06	9. AGE (In years last birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY HW	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Kellam		14. MOTHER'S MAIDEN NAME Mary Etta Mason			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Gerlena Drummond 717 N Carey		
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Carcinoma of lung		INTERVAL BETWEEN ONSET AND DEATH 7/29/65	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 6 1965 to Nov 5 1965, that (I) (we) last saw the deceased alive on Nov 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death.					
23A. SIGNATURE J. N. Mac Murchy M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov 5/65	
23C. PHYSICIAN'S NAME (Type) J. N. MAC MURCHY		23D. ADDRESS 500 E Madison St Balto Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-11-65		24C. NAME OF CEMETERY or CREMATORY Accomac Co. VA.	
24D. LOCATION VA.		25A. DATE REC'D BY HEALTH DEPT. NOV 9 1965		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Winton Funeral Home		ADDRESS VA.			





BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SYLVESTER PARKER

2. DATE AND HOUR PRONOUNCED DEAD

11-6-65

9:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

730 Mura St.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

March 27, 1950

9. AGE (In years  
last birthday)

15

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Miner

10B. KIND OF BUSINESS OR INDUSTRY

Miner

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Parker

14. MOTHER'S MAIDEN NAME

Dra Mae Samuels

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

William Parker Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of head  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

alley

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

alongside 1218 Brentwood Ave.

21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

11-6-65 8:55 P.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

shot during robbery (attempted)

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-7-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-12-1965

23C. NAME of CEMETERY or CREMATORY

Balt. Nat. Cem.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 9 1965

24B. NAME OF REGISTRAR

Rudiger Breitenecker

24C. FUNERAL DIRECTOR

Choy O. Wilson 1000 Beantley Ave

ADDRESS

VALLEY FORDGE

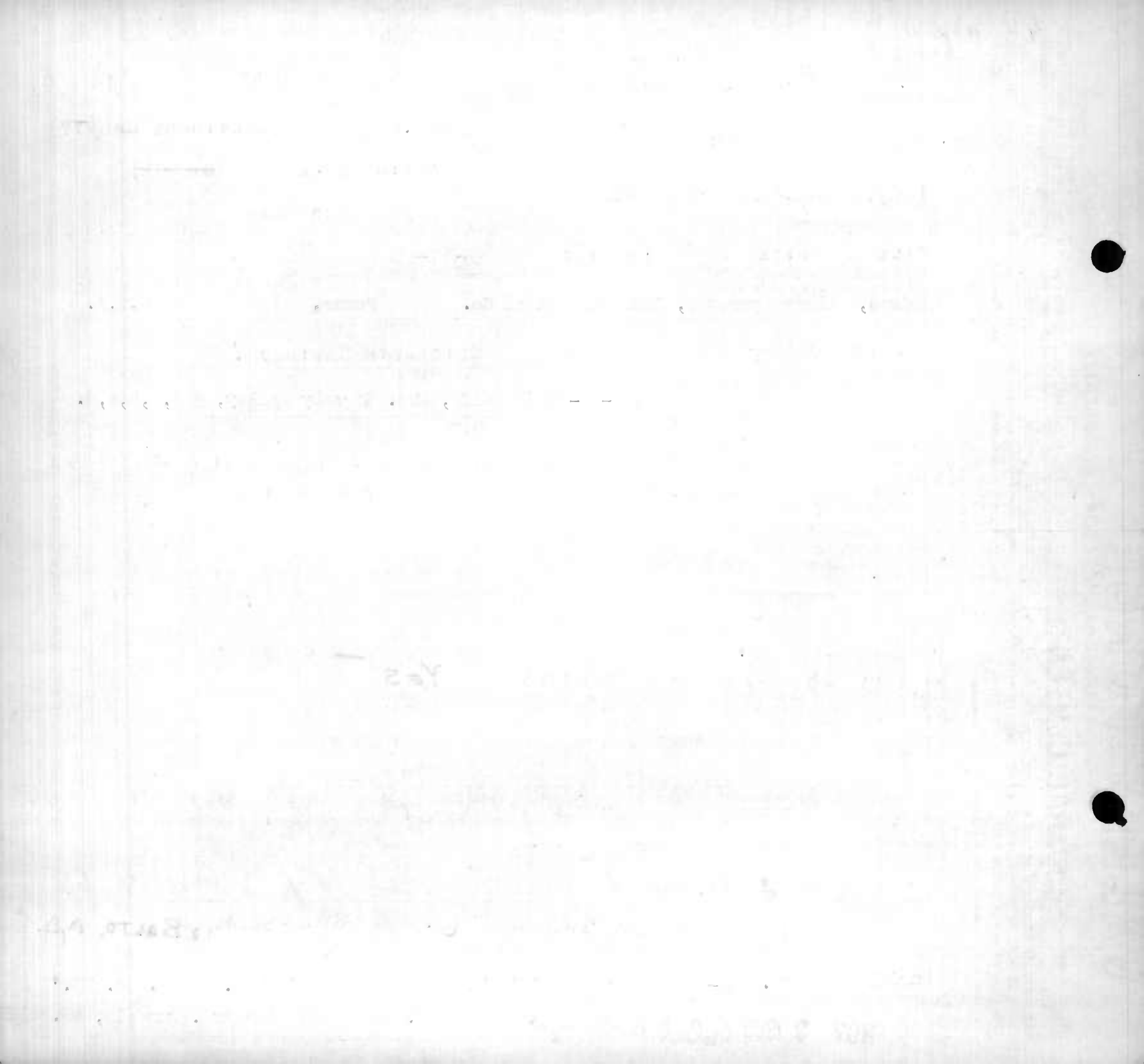
HAD CO. ST. MONT.

UTAH

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11456		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11456	
M.E. CASE NO.		ROBERT HALLEY		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HALLEY Robert		2. DATE AND HOUR OF DEATH 11-7-65 748 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY (BALTIMORE COUNTY)			
3 Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE 22 (Dundalk) 5300			
		D. STREET ADDRESS (If rural, give location)			
		1937 CHURCH ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-11-98	9. AGE (In years last birthday) 67	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Shear Operator, Bethlehem Steel Co.		10B. KIND OF BUSINESS OR INDUSTRY Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN Halley		14. MOTHER'S MAIDEN NAME ELIZABETH DAVIDSON.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 213-07-0584		17. INFORMANT ADDRESS Wife, Mrs. Dorothy Halley, # 4, a, b, c, d.	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) INFARCTION of (L) CEREBRAL Hemisphere		INTERVAL BETWEEN ONSET AND DEATH 51 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 29-14-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CAROTID STENOSIS		20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from Sept 11 19 65 to Nov 7 19 65, that (we) last saw the deceased alive on 7 Nov 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lincoln Jeanes, Jr. M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-7-65	
23C. PHYSICIAN'S NAME (Type) LINCOLN JEANES, JR. M.D.		23D. ADDRESS 601 N. BROADWAY, BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 10-1965		24C. NAME of CEMETERY or CREMATORY Gardens of Faith	
				24D. LOCATION (City, town, or county) (State) Trumps Mill Rd. Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 9 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 21222	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 11457</b>		<b>CERTIFICATE OF DEATH</b>		BALTIMORE CITY HEALTH DEPT.		Registered No. <b>65 11457</b>	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>HYMAN HURWITZ</b>				2. DATE AND HOUR OF DEATH <b>Nov. 7, 1965 5:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 MT SINAI NURSING HOME</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-16</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BELT MORE</b> D. STREET ADDRESS (If rural, give location) <b>4613 PARK HEIGHTS AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>1884</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRESSER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>NOT KNOWN</b>				14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-03-1926</b>		17. INFORMANT <b>HOSPITAL CHART</b>			
18. <b>420.14-260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis</b>  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Acute</b> <b>conkwon</b> <b>years.</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 1963</b> to <b>Nov. 7 1965</b> , that (I) (we) last saw the deceased alive on <b>Nov. 5 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>David I. Miller</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>Nov. 7 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>David I. Miller</b>				23D. ADDRESS <b>Sinai Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/9/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>HEBREW FRIENDSHIP</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.A.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SYLVAN S. LEWIS &amp; SON, INC. - 3319 OLYMPIA AVE</b>			

FRIENDSHIP

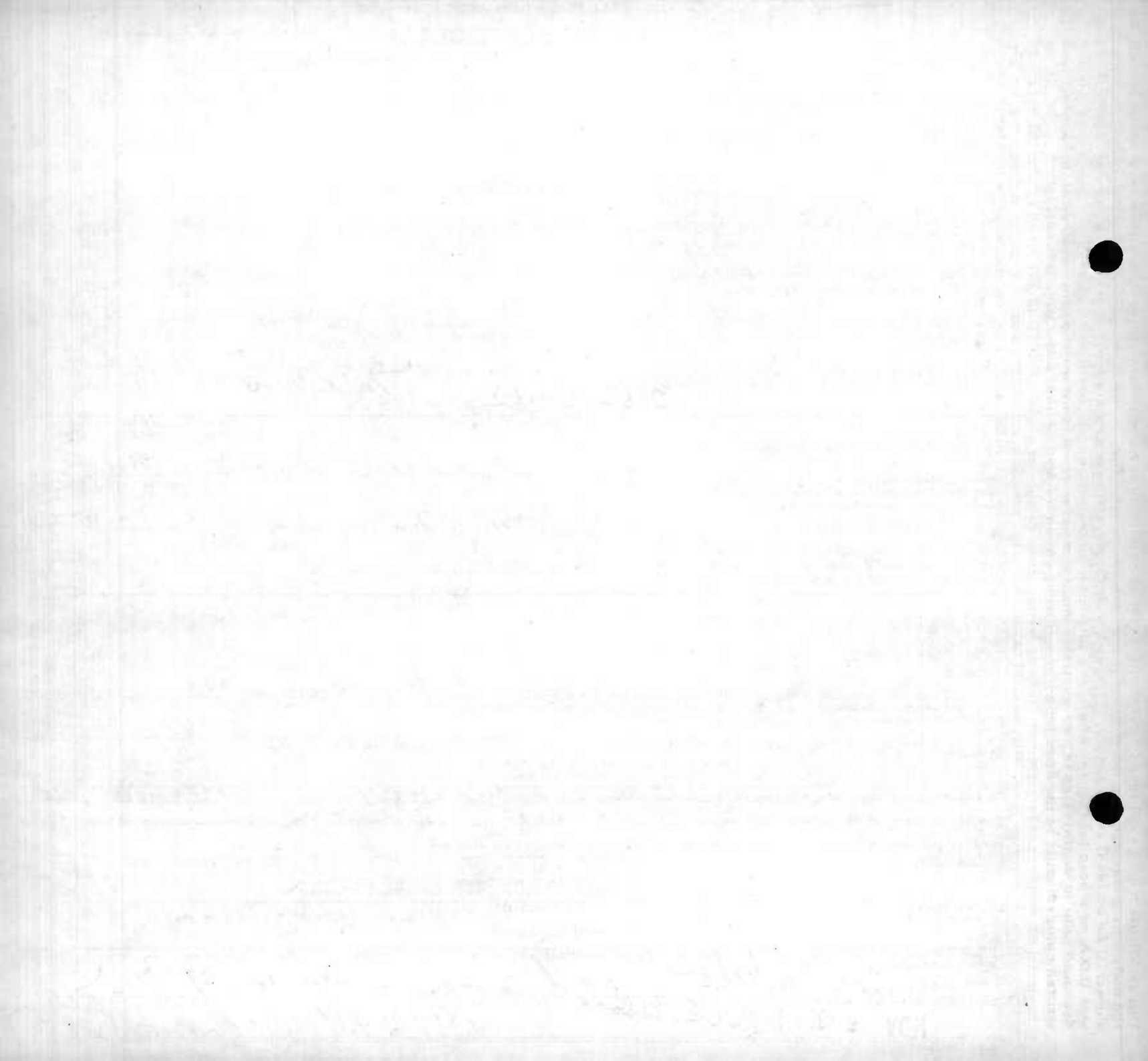


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 2em;">(12)</span> 65 11458		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65 11458	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>De RUSHA, S. Victor</b>			2. DATE AND HOUR OF DEATH <b>11-8-65</b>   <b>1</b> a. m.		
3. PLACE OF DEATH IN BALTIMORE MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bon Secours Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> 21207 6300 D. STREET ADDRESS (If rural, give location) <b>2127 Southland Rd.</b> 21207		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>May 29, 1908</b>	9. AGE (In years last birthday) <b>57</b>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dist. Sales Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Prudential Ins.</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>	
13. FATHER'S NAME <b>DeRusha, S.A.</b>			14. MOTHER'S MAIDEN NAME <b>LORRAR</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-07-7262</b>		17. INFORMANT <b>Mildred M. DeRusha</b> Address <b>Admission Sheet</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>THROMBOSIS OF RT. CORONARY ART.</b> DUE TO (B) <b>Recent INFARCTION, Post. Wall, Lt. Ventricle.</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>November 7</b> 19 <b>65</b> to <b>November 8</b> 19 <b>65</b> , that <del>the</del> (we) last saw the deceased alive on <b>November 8</b> 19 <b>65</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) (and not) view the body after death.					
23A. SIGNATURE <b>PICHAIT WATHANAPANARL</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>11/8/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>PICHAIT WATHANAPANARL</b>		23D. ADDRESS <b>Bon Secours Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/11/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Smith</b>		25C. FUNERAL DIRECTOR <b>Witte F.W. 4101 Edmondson</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 6 65 11459				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11459	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Harry David Schmidt				Nov. 8/65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
709 Nottingham Rd. Apt. 3 A				Md.		28-04	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				709 Nottingham Rd. Apt. 3 A			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	White	Married	Dec. 29/87	77			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired					Balto. Md.		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
-----Schmidt				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
			none		Mrs. Marguerite Schmidt, 709 Nottingham		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		5 YRS +	
				ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 19 63 to 11/8 19 65, that (I) (we) last saw the deceased alive on 11/5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Thos E Roach						11/9/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Thos E Roach				M.D. 5550 BARTON N. 2 PINE BARTON-28-14d			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		11/10/65		Most Holy Redeemer		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 9 1965		Robert E. Farkner		Witzke F.D. 4101		Edmondson	

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BIRTH NO. 65 11460		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11460	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Howard August Bottiger</i>		2. DATE AND HOUR PRONOUNCED DEAD 11-7-65 5:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  BALTIMORE CITY HOSPITAL - DOA		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>6947 McLean Blvd</i> 21234			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>10-16-1898</i>	9. AGE (In years last birthday) <i>67</i>	10. IF Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Crown Cork &amp; Seal Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>George Bottiger</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Ann Bittner</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212097947</i>		17. INFORMANT <i>Mrs Daisy E. Bottiger</i> ADDRESS <i>same</i>	
18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Hypertensive cardiovascular disease</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type) <i>RUSSELL S. FISHER, M.D.</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>11-8-65</i>	
23A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		23B. DATE <i>11-11-65</i>		23C. NAME of CEMETERY or CREMATORY <i>Moreland Mem. Park</i>	
23D. LOCATION <i>Baltimore, Md.</i>		24A. DATE REC'D BY HEALTH DEPT. <i>NOV 9 1965</i>		24B. NAME OF REGISTRAR <i>Robert E. Fisher</i>	
24C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>		24D. ADDRESS <i>Baltimore, Md.</i>			

VALLEY FORCE

IN CONTACT

US A

10/27

WIND A 10/27

*[Handwritten signature]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11461		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11461	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BARBARA M. HUNT		2. DATE AND HOUR OF DEATH 11/9/65 3:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2825 OVERLAND AVE			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP.		(If not in hospital or institution, give street address or location)			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH MARYLAND 73	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ↓ ↑ 11-1-92	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN ORMINER		14. MOTHER'S MAIDEN NAME Rose Lessner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 216-10-5468A ← UNIC		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS GEO. HUNT 4605 SUNBROOK AV.	
18. 175.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) RESPIRATORY INFECTION DUE TO (B) CARCINOMA OF OVARY DUE TO METASTASES (C)		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 2 MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 2:15 PM 10/30/65 to 2:25 AM 11/9/65, that (H) (we) last saw the deceased alive on 3:25 AM 11/9/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ROBERT N. WHITLOCK				23B. DATE SIGNED 11/9/65	
23C. PHYSICIAN'S NAME (Print) ROBERT N. WHITLOCK		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 11-12-65		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 9 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc Baltimore, Md.	

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65 11462

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11462

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)Rosario  
FRANK (FRANCIS) MUFFOLETTO

2. DATE AND HOUR PRONOUNCED DEAD

11-8-65

2:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3209 BEVERLY ROAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3209 Beverly Road 21214

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

April 25, 1908

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Muffoletto

14. MOTHER'S MAIDEN NAME

XXXXXXXX Angela Presti

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

217-16-0029

17. INFORMANT

ADDRESS

C. Verne Muffoletto, 9411 Flagstone Drive

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty infiltration of liver, marked  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Acute alcoholism

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-8-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11/11/65

23C. NAME of CEMETERY or CREMATORY

HOLY REDEEMER CEMETERY

23D. LOCATION

(City, town, or county)

BALTO., MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 9 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

LEONARD J. RUCK, INC., BALTO., MD. 21214

WALKER JONES

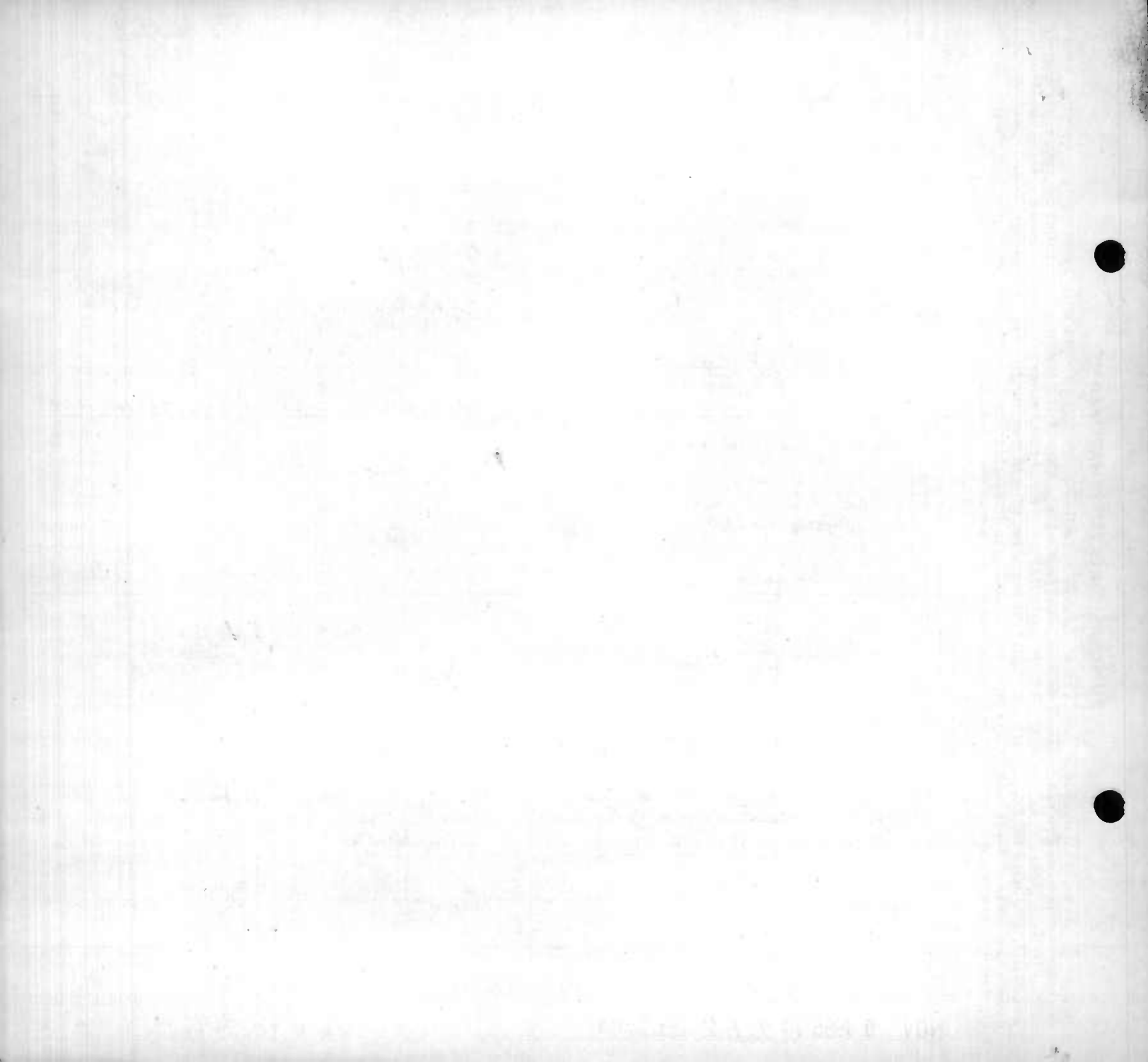
PROSECUTOR

*[Signature]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

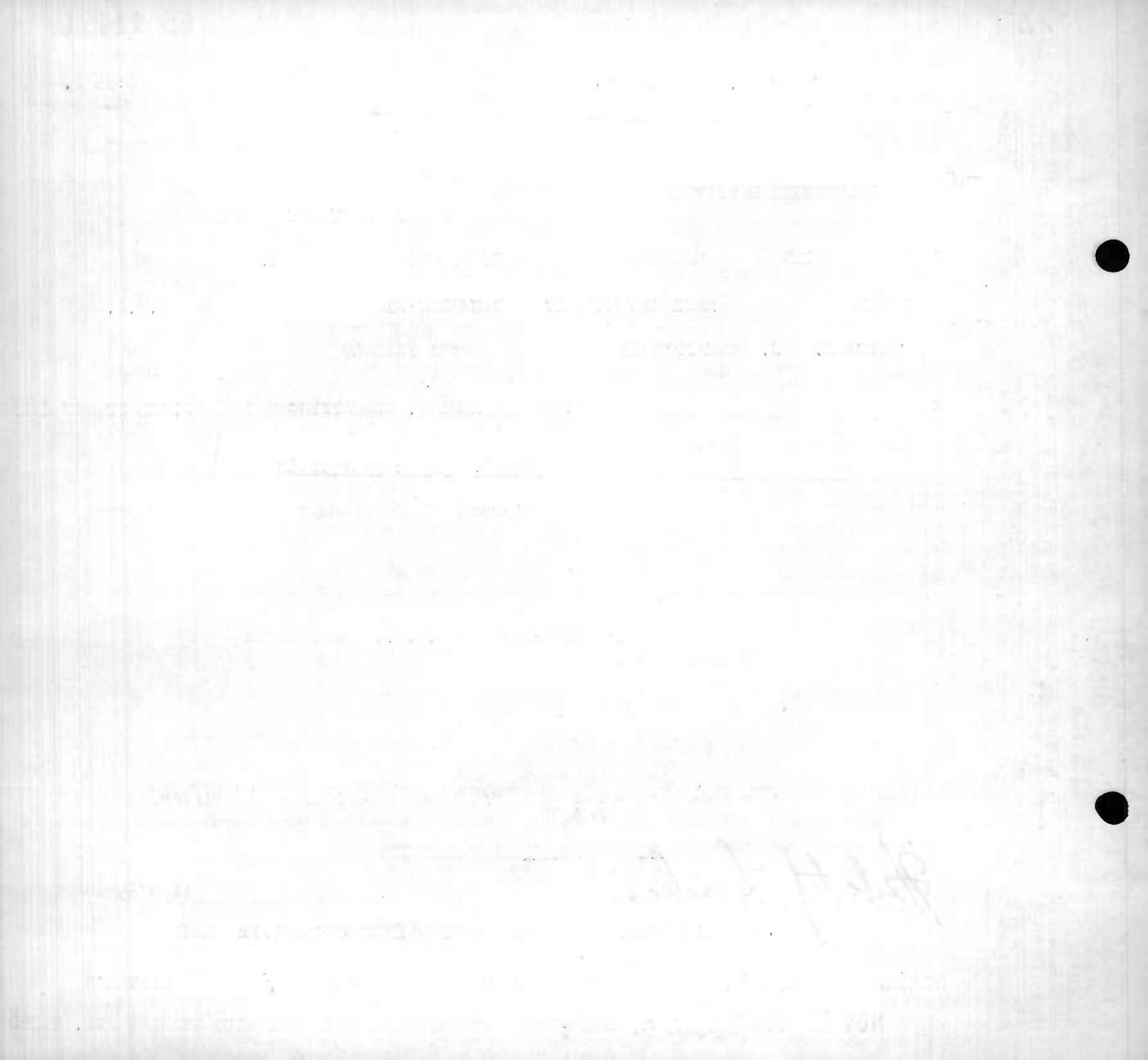
BIRTH NO. 65 11463		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 11463	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Emma Eley (Lee)			2. DATE AND HOUR OF DEATH 11/8/65 5:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 20-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2013 Edmondson Ave.		
5. SEX Fe	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/25/02	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Oklahoma City, OKA.	
13. FATHER'S NAME Archie White			14. MOTHER'S MAIDEN NAME UNK.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Eley 2013 Edmondson Ave.	
18. 493XVI 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Pneumonia DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertro; Diabetes mellitus; Pyelonephritis					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 17, 1965 to September 8, 1965, that (I) (we) last saw the deceased alive on November 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert C. Blackman			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) Robert C. Blackman			23D. ADDRESS Lutheran Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-11-65		24C. NAME OF CEMETERY or CREMATORY MT. Auburn	
24D. LOCATION MT. Auburn (Balt.), Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 9 1965		24F. NAME OF REGISTRAR Robert E. Faley	
24G. FUNERAL DIRECTOR MORTON + Dye II		24H. ADDRESS 1701 Laurens			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <b>65 11464</b>		Registered No. <b>65 11464</b>	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				<b>GEORGE L. SCHNAPPINGER</b>		<b>11/7/65</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		6:55 P. M.	
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location)				<b>MARYLAND</b>		<b>25-43</b>	
<b>UNIVERSITY HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<b>BALTIMORE</b>	
				D. STREET ADDRESS (If rural, give location)		<b>2103 MAISEL STREET 21230</b>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>3/27/1890</b>	
9. AGE (In years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE KX J. SCHNAPPINGER</b>				14. MOTHER'S MAIDEN NAME <b>EVA SEEBOLD</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>ANNA E. SCHNAPPINGER 2103 MAISEL STREET 21230</b>	
18. CAUSE OF DEATH <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <b>Uremia due to polycystic disease of the kidneys</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
(B) <b>disease of the kidneys</b>				(C) _____		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic C.V.D., generalized</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>8/4/1950</b> 19 to <b>11/7/65</b> 19 that (I) (we) last saw the deceased alive on <b>9/24/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Herbert J. Levickas</i>	
23B. DATE SIGNED <b>11/9/65</b>				23C. PHYSICIAN'S NAME (Type) <b>HERBERT LEVICKAS</b>		23D. ADDRESS <b>1073 MAIDEN CHOICE XXXX LANE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/10/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21230</b>		25D. ADDRESS <b>29</b>	



BIRTH NO. 65 11465		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 65 11465	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
JOSEPH M. McKENNA, SR.				2. DATE AND HOUR PRONOUNCED DEAD			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
ST. AGNES HOSPITAL - DOA				Maryland Baltimore			
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH 9. AGE (In years last birthday)			
Male White MARRIED				12/4/1910 XXX 54			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Supply man				CA LVERT DISTILLERY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
MARYLAND				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN McKENNA				MARIE HEALEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
NO				212-05-2471			
17. INFORMANT				ADDRESS			
MRS. MARY B. McKENNA				3405 WASHINGTON BLVD. 21229			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Coronary artery sclerosis			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				Arteriosclerotic heart disease			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
2				20A. AUTOPSY? (Yes or No)			
				Yes			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
				WHILE AT WORK NOT WHILE AT WORK			
21F. HOW DID INJURY OCCUR?							
22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from:				Natural causes Accident Suicide Homicide Undetermined manner			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER			
RUSSELL S. FISHER, M.D.				DATE SIGNED			
23A. BURIAL CREMATION, REMOVAL (Specify)				23B. DATE			
BURIAL				11/10/65			
23C. NAME of CEMETERY or CREMATORY				23D. LOCATION (City, town, or county) (State)			
NEW CATHEDRAL CEMETERY				BALTIMORE, MARYLAND			
24A. DATE REC'D BY HEALTH DEPT.				24B. NAME OF REGISTRAR			
NOV 10 1965				Robert E. Fisher, M.D.			
24C. FUNERAL DIRECTOR				ADDRESS			
HUBBARD FUNERAL HOME				4107 WILKENS AVE. 21229			



VALLEY FOLIO

PRO CLINT

10

*Handwritten signature*

65 11466

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11466

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

NICHOLAS JACK LEVRERO

2. DATE AND HOUR PRONOUNCED DEAD

November 6, 1965

5:15 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Pa.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Tamaqua

D. STREET ADDRESS (If rural, give location)

R.F.D.2

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

October 1, 1921

9. AGE (in years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Electronics

11. BIRTHPLACE (State or foreign country)

California

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Nicholas J. Levrero

14. MOTHER'S MAIDEN NAME

? Rader

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Gloria Levrero, Rt.2, Tamaqua, Pa.

18. 353.31-E903.5

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral injuries  
DUE TO epilepsy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

7315 Harford Rd.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11 4 65 11:07P

21E. INJURY OCCURRED

WHILE AT  
WORK ☒NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

fell during seizure

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/10/65

23C. NAME of CEMETERY or CREMATORY

Rush Township Cem

23D. LOCATION

(City, town, or county)

(State)

Schuylkill Co., Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.

NOV 12 1965

24B. NAME OF REGISTRAR

Robert E. Fickel

24C. FUNERAL DIRECTOR

ADDRESS

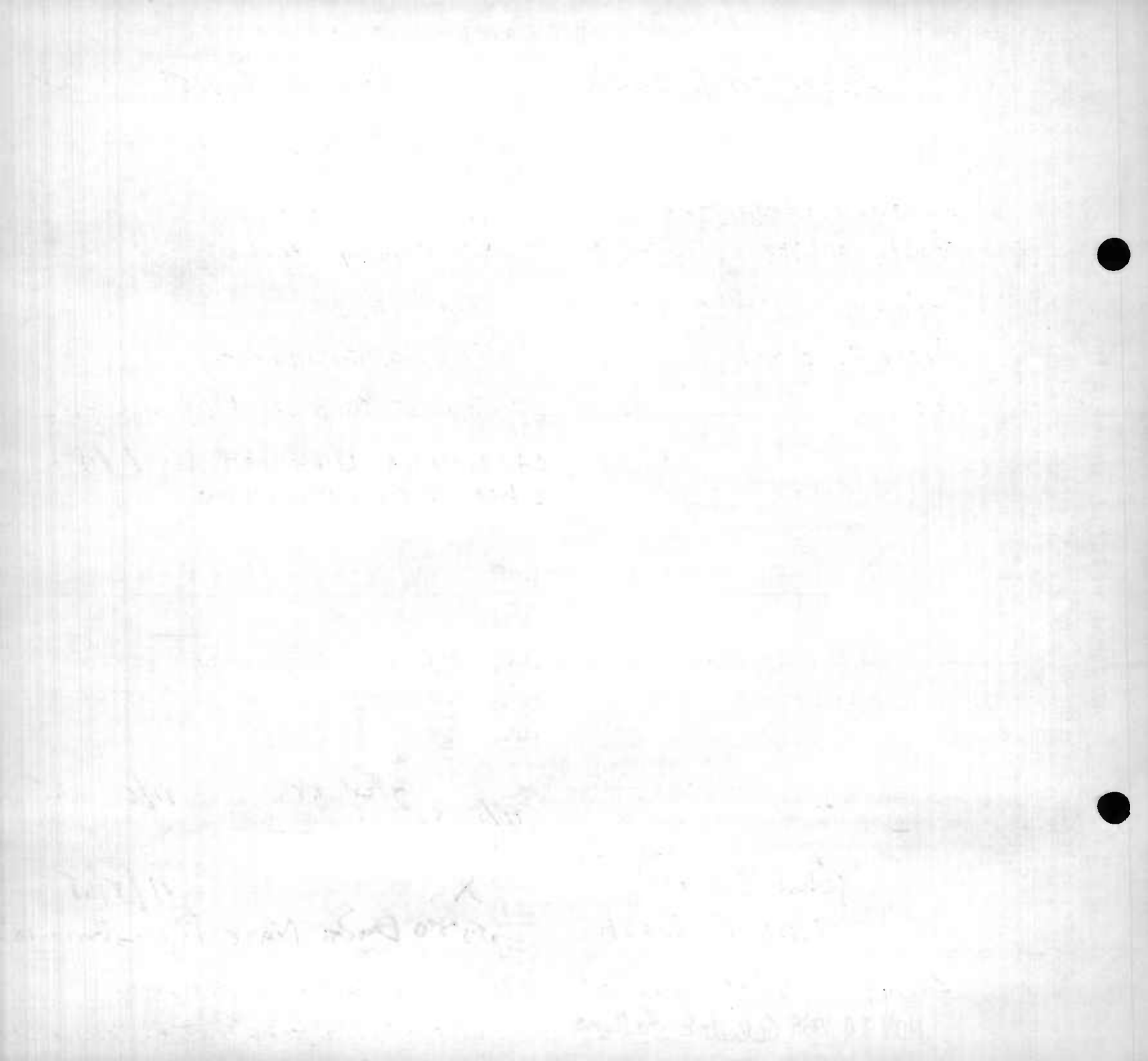
Ullrich Funeral Home Baltimore, Md.

WALTER B. DORRIS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

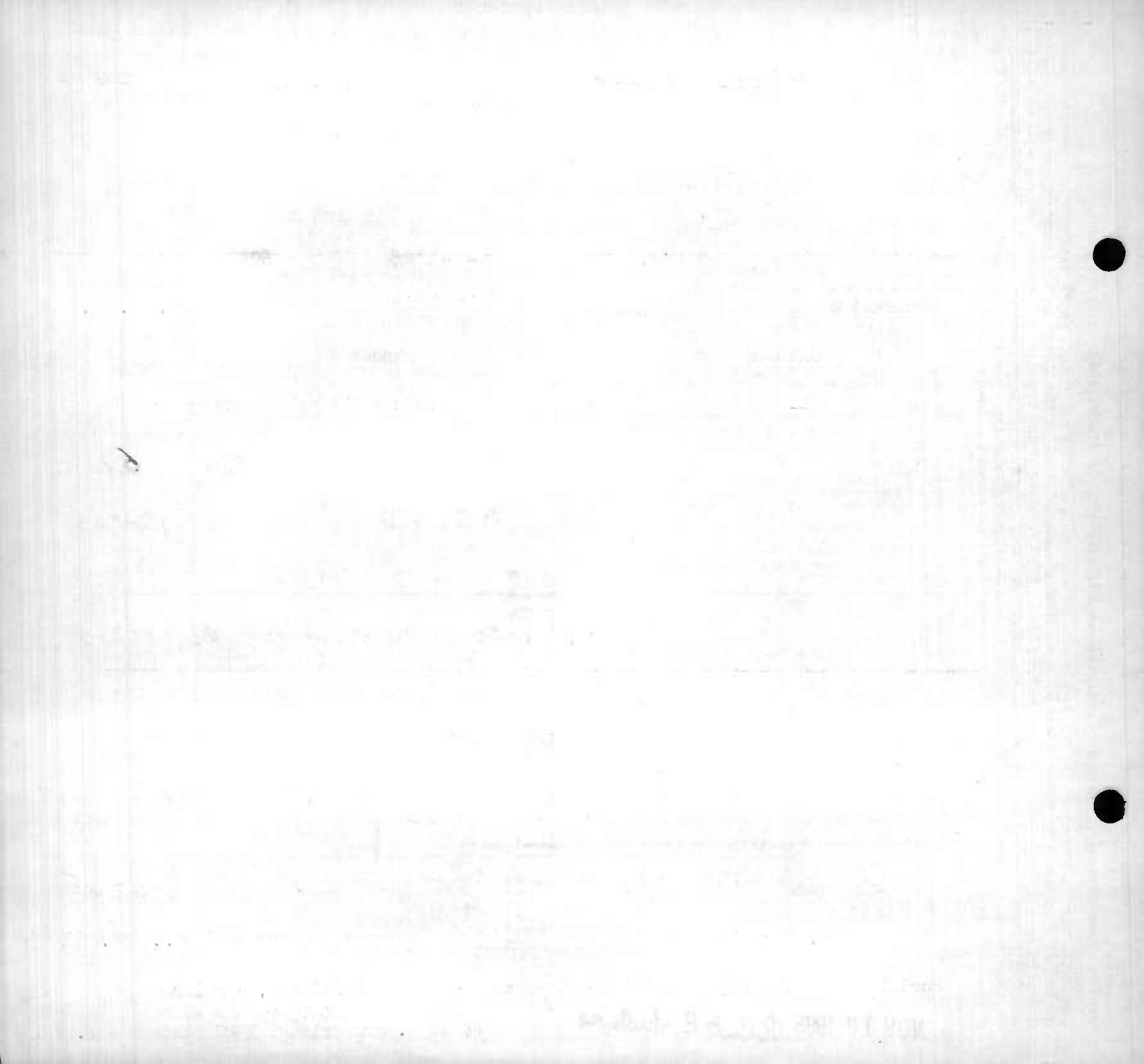
BIRTH NO. 65 11467		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11467	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Elizabeth T. Bach		2. DATE AND HOUR OF DEATH November 6, 1965 2 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5300	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5319 Edmondson Ave.		D. STREET ADDRESS (If rural, give location) 411 Wilkens Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH November 13, 1894	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Jacob J. Bach		14. MOTHER'S MAIDEN NAME Thecla Brunner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-2512		17. INFORMANT Margaret Bach 1100 Maryland Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO CARDIOMA Breast e. Generalized Metastases (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 Yr - 1	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/25/1965 to 11/6/1965, that (I) (we) last saw the deceased alive on 11/5/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thos E. Roach		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/8/65	
23C. PHYSICIAN'S NAME (Type) Thos E. Roach		23D. ADDRESS 5530 B&O NATL PKW, Balto-28			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker Sts	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 11468</u>	
BIRTH NO. <u>F 430 65 11468</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MABEL FULDA</u>		<u>11-6-65</u>   <u>2:15 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Essex</u>	
5. SEX <u>Female</u>		D. STREET ADDRESS (If rural, give location) <u>2 Louella Avenue 21220</u>	
6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6-2-1896</u>	9. AGE (In years last birthday) <u>69</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>RECORDS: BCH 4940 Eastern Avenue 21224</u>		ADDRESS	
18. <u>420.1+1260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>		(B) <u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes mellitus, Chronic Lung Dis.</u>		<u>Years</u>	
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5</u> 19 <u>65</u> to <u>Nov. 6</u> 19 <u>65</u> , that (I) <del>was</del> last saw the deceased alive on <u>Nov. 6</u> 19 <u>65</u> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>did not</del> view the body after death.			
23A. SIGNATURE <u>Laurice McAfee</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>11-6-65</u>
23C. PHYSICIAN'S NAME (Type) <u>Dr. Laurice McAfee</u> M.D.			23D. ADDRESS <u>4940 Eastern Avenue Balto., Md. 21224</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11/9/65</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldy</u>	
25C. FUNERAL DIRECTOR <u>James E. Bruzdziński</u>		ADDRESS <u>1407 Eastern Ave. #21</u>	





1

65 11469

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11469

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MARY E. DENMAR

2. DATE AND HOUR PRONOUNCED DEAD November 5, 1965 9:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Carroll

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sykesville

D. STREET ADDRESS (If rural, give location) Streaker Rd.

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital

5. SEX female

6. RACE negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec. 13, 1906

9. AGE (In years last birthday) 58

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Nugent

14. MOTHER'S MAIDEN NAME Mary Wilkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 212 22 3671

17. INFORMANT Mr. Douglas Denmar

ADDRESS Sykesville, Md.

18. CAUSE OF DEATH

(A) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease and multiple pulmonary emboli

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 11-6-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 11-9-65

23C. NAME OF CEMETERY or CREMATORY White Rock Cemetery

23D. LOCATION (City, town, or county) (State) Sykesville, Md.

24A. DATE REC'D BY HEALTH DEPT. NOV 10 1965

24B. NAME OF REGISTRAR Robert E. Farkner

24C. FUNERAL DIRECTOR Harry W. Haight

ADDRESS Sykesville, Md.

WALTER E. POE

DEPT. OF JUSTICE

NOV 19 1964

NOV 19 1964

# FUNERAL DIRECTOR: IMPORTANT

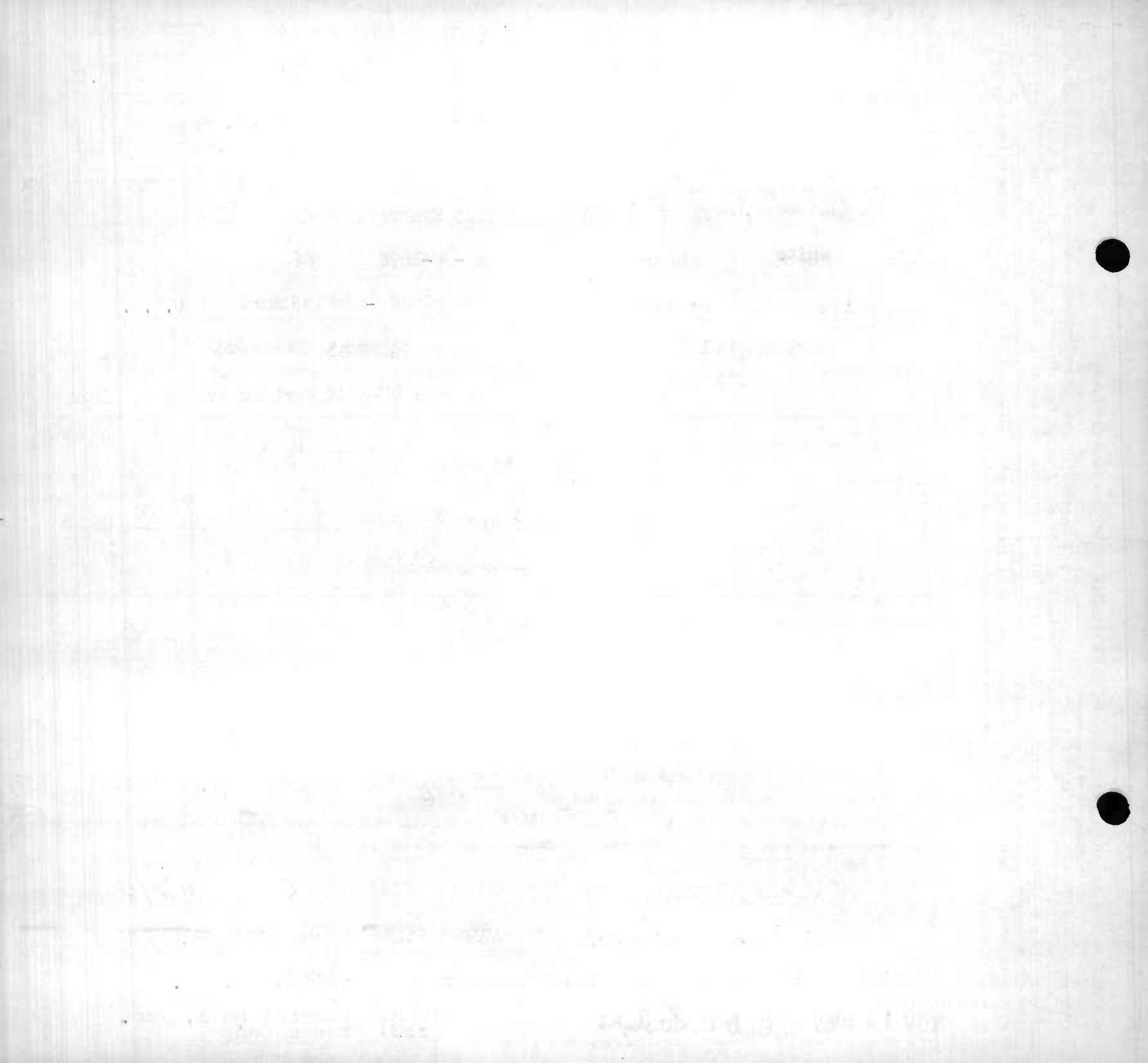
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11470				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11470	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA CERMAK				2. DATE AND HOUR OF DEATH 8 November 1965   12:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1202 ARGONNE DR.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 1202 ARGONNE DR.			
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH MAY 4-1873	9. AGE (In years last birthday) 92	10. Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY? CZECHOSLOVAKIA	
13. FATHER'S NAME JAMES CERMAK				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT BERTHA BUDALZ		ADDRESS 1202 ARGONNE DR. BALTO. MD.	
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) Gastro-intestinal Hemorrhage DUE TO (B) Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 4 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 19 63 to Nov. 8 19 65, that (I) (we) last saw the deceased alive on Nov. 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE Clarence W. LeDoux M.D.				23B. DATE SIGNED 11/7/65			
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux M.D.				23D. ADDRESS 3023 Eastern Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT		24B. DATE 11-10-65		24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK CEM.		24D. LOCATION (City, town, or county) (State) BALTO.; MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR Wm. A. Tralkowski		ADDRESS 2007 Eastern Ave. Balto. md. 21231	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11471		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11471	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Marie Fletcher Anna/Gleason		2. DATE AND HOUR OF DEATH 11-8-1965 9.40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) (Rural) 6300 D. STREET ADDRESS (If rural, give location) 7745 Wynbrook Road 21224			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 11-30-1898	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland - Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Martin Hill		14. MOTHER'S MAIDEN NAME Ida <del>XXXX</del> Gassaway	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Myocardial Infarction (B) DUE TO Hypertension (C) <del>Myocardial</del> diabetes mellitus obesity		INTERVAL BETWEEN ONSET AND DEATH 2 days 15 years "	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/6 19 65 to 11/8 19 65, that (I) (we) last saw the deceased alive on 11/8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Pierce Curtiss Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/8/65	
23C. PHYSICIAN'S NAME (Type) David Pierce Curtiss Jr.		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/65		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11472		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11472	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ELMA G. MEINERS</b>			2. DATE AND HOUR OF DEATH <b>Nov. 8, 1965</b> <b>8:08 a.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Gould Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.,</b> B. COUNTY <b>26-10</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>524 N. Highland Ave.</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>7/17/1887</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>William A. Lilly</b>			14. MOTHER'S MAIDEN NAME <b>Rebecca LeBrun</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-05-8842</b>		17. INFORMANT <b>Rebecca Meiners, dght. above</b>	
18. <b>450.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>			CAUSE OF DEATH (A) <b>Advanced Senile Dementia</b> DUE TO (B) <b>Age</b> DUE TO (C) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>	
21D. TIME OF INJURY (APPROX.) <b>None</b>		21E. INJURY OCCURRED While At <input type="checkbox"/> Home <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>None</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>July 19 65</b> to <b>Nov 8 19 65</b> , that (I) (we) last saw the deceased alive on <b>November 2 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles P. Crimy</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/9/65</b>
23C. PHYSICIAN'S NAME (Type) <b>Dr. Charles P. Crimy</b>			23D. ADDRESS <b>2722 E. Monument St.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/11/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>	





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 11473	
BIRTH NO. 5-395 65 11473				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) SEDLMAYER, Mary	
2. DATE AND HOUR OF DEATH 11/8/65				5:35 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MARYLAND	
BALTIMORE CITY HOSPITALS				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
4940 EASTERN AVENUE				BALTIMORE	
BALTIMORE, MARYLAND 21224				D. STREET ADDRESS (If rural, give location)	
8017 Shore Road					
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	
8. DATE OF BIRTH 8/16/86		9. AGE (In years lost birthday) 79		10. If Under 1 Yr. Months Days	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Haberkam				14. MOTHER'S MAIDEN NAME Caroline Roebuck	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT RECORDS				ADDRESS BCH: 4940 Eastern Avenue - 21224	
18. 433.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH	
ANTECEDENT CAUSES				(A) DUE TO CARDIAC ARREST	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO ASCVD	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) NONE	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from on 11/8/1965 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clayton L. Moravec				23B. DATE SIGNED 11/8/65	
23C. PHYSICIAN'S NAME (Type) Clayton L. Moravec				23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/10/65		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) Balto. Co.		24E. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Connolly 300 Mace Ave. Balto. 21	

George Washington

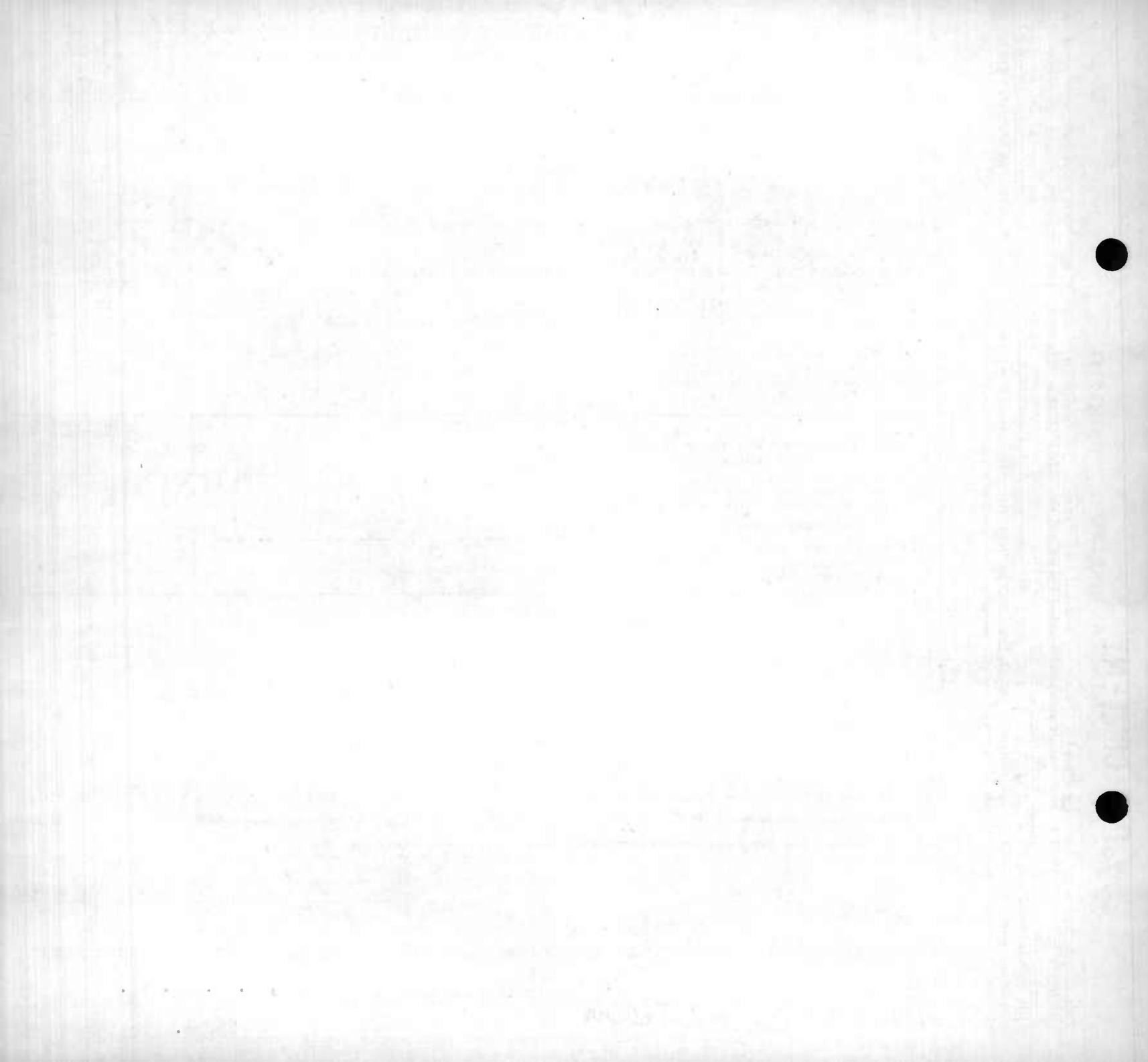
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Continental

General Wm. C. C. Lee

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

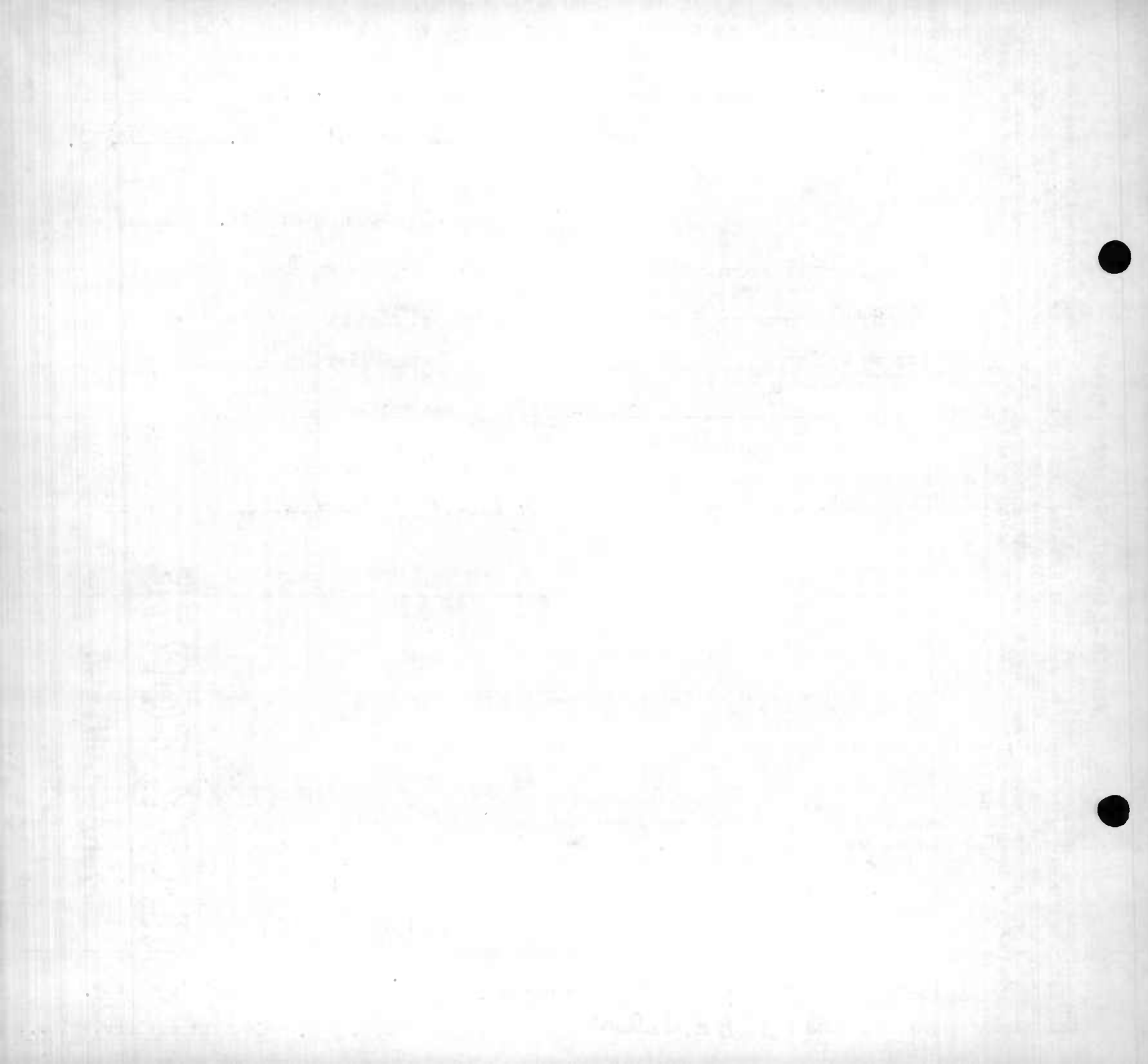
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 11474		CERTIFICATE OF DEATH		Registered No. 65 11474		
1. NAME OF DECEASED (Type or Print) <b>HOLMES CLARENCE WILMER</b>				2. DATE AND HOUR OF DEATH <b>November 8, 1965 15 40 P.M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>NORTH CHARLES GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CITY</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1739 BELT ST.</b>						
5. SEX <b>MALE</b>	6. RACE <b>AMERICAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Nov. 6, 1879</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Stationary Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JACOB HOLMES</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE HOLMES</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Spanish American</b>		16. SOCIAL SECURITY NO. <b>212 07 9712</b>		17. INFORMANT <b>HOSPITAL RECORD</b>			ADDRESS			
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Intermittent Cardiac - Vascular Disturbance, Hypertension</b> (B) <b>Thrombosis</b> (C) <b>Coronary Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>November 2, 1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>gall</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>October 21, 1965</b> to <b>November 8, 1965</b> , that (I) (we) last saw the deceased alive on <b>November 8, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE <b>W. H. Gunning</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>November 8, 1965</b>				
23C. PHYSICIAN'S NAME (Type) <b>WALTER KOHN</b>				23D. ADDRESS M.D.						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11 12 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, A. A. Co. Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Mc Cully</b>		ADDRESS <b>130 E. Fort Av</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11475				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11475	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BENJAMIN GALLER</b>				2. DATE AND HOUR OF DEATH <b>Nov. 8, 1965</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4100 Loch Raven Blvd.</b>			
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>9/1/1890</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		
13. FATHER'S NAME <b>Mosheh Galler</b>			14. MOTHER'S MAIDEN NAME <b>Chava Galler</b>			12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>?</b>			16. SOCIAL SECURITY NO. <b>219-32-1756</b>		17. INFORMANT <b>Nat. Miller</b>		
18. <b>420.1 d 260 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic heart disease</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes mellitus</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> 19 <b>65</b> to <b>11/8</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Oct 31</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>Medical Examiner notified</b>							
23A. SIGNATURE <b>Robert I. Levy</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert I. Levy</b>				23D. ADDRESS <b>114 Medical Arts Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/9/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>United Hebrew Cem. Washington</b>		24D. LOCATION (City, town, or county) (State) <b>Moses Montifiore Cong. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JACK LEWIS, INC. 2100 Eutaw Place, Balto., Md.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

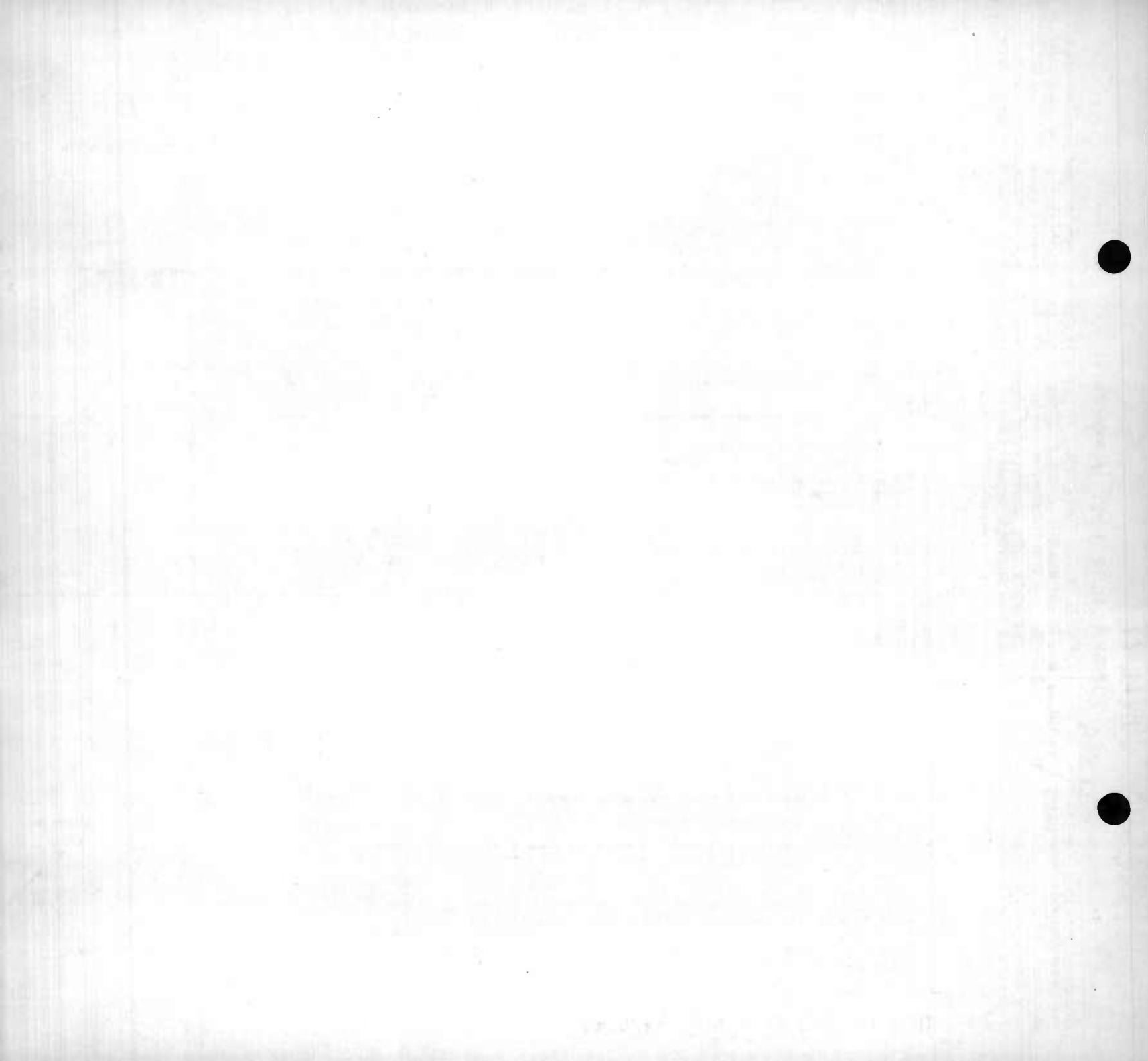
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 11476		CERTIFICATE OF DEATH		65 11476	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>EMMA COX</b>		2. DATE AND HOUR OF DEATH <b>11/7/65 10:00 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 18</b> D. STREET ADDRESS (If rural, give location) <b>328 Whitridge Ave</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jun 10 1897</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Medford</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Crossen</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Catherine Pfeiffer</b> ADDRESS <b>7843 Balto Ave #24</b>	
18. <b>420.14260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>		CAUSE OF DEATH (A) <b>Acute Pulmonary Edema</b> DUE TO <b>cardiac arrest</b> (B) <b>Acute myocardial infarction</b> DUE TO <b>—</b> (C) <b>Generalized ASCVD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
19A. DATE OF OPERATION <b>0 —</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (the hospital) attended the deceased from <b>Nov 7 (9:15 PM) 1965</b> to <b>Nov 7 (10 PM) 1965</b> , that (I) (we) last saw the deceased alive on <b>Nov 7 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/7/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. J. ROLLIN OTTO JR.</b>		23D. ADDRESS <b>1016 Saint Paul St 21202</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/11/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Louisa Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE RECD BY HEALTH DEPT. <b>NOV 10 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home</b> ADDRESS <b>4107 Wilkens Ave. #19</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">65 11477</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 1.5em;">65 11477</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BENJAMIN FRANKLIN CLINE</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">NOV. 8, 1965 11:50 PM</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">25-04</span>		5. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">FRANKLIN SQUARE HOSPITAL</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">47 TALBOT ST</span>			
6. SEX <span style="font-size: 1.2em;">M</span>	7. RACE <span style="font-size: 1.2em;">W</span>	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	9. DATE OF BIRTH <span style="font-size: 1.2em;">JULY 4, 1899</span>	10. AGE (In years lost birthday) <span style="font-size: 1.2em;">66</span>	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Hoffberger O.T.C.</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MICHIGAN</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">UNKNOWN</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">UNKNOWN</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Family</span>	
18. <span style="font-size: 1.2em;">420.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CARDIAC FAILURE</span>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">MYOCARDIAL INFARCTION</span> <span style="font-size: 1.2em;">ARTERIOSCLEROTIC HEART DISEASE</span> <span style="font-size: 1.2em;">Pulmonary infarction 20 &amp; emboli from heart</span>		20. INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>W</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">Nov. 2</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">Nov. 8</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">11:50 PM</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Michael H. Pedronis</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">11-9-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">M.D.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">11-12-65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Cedar Hill Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto 25 md</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">NOV 10 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farkner</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">McCully Funeral Home 237 Park Ave</span>	
ADDRESS <span style="font-size: 1.2em;">237 Park Ave</span>					



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11478		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11478	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>ROXIE &amp; MANLEY</b>		
2. DATE AND HOUR OF DEATH			10-29-65 7:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME &amp; HOSPITAL</b>			A. STATE <b>Maryland</b> B. COUNTY <b>USA</b> <b>Balt</b>		
5. SEX <b>F</b>			6. RACE <b>W</b>		
7. <del>MARRIED</del> NEVER MARRIED <b>WIDOWED</b> DIVORCED (specify)			8. DATE OF BIRTH <b>9-7-93</b>		
9. AGE (In years lost birthday) <b>72</b>			10. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John P. Staton</b>			14. MOTHER'S MAIDEN NAME <b>Donna Ellen Donals</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Paul Manley</b>			ADDRESS <b>3535 Dunhaven Rd. 21222</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>arteriosclerotic cardiovascular disease</b> <b>years</b>		
			(B) <b>diabetes mellitus</b> <b>years</b>		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-29-65</b> to <b>10-29-65</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>10-29-65</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did)</b> <b>(did not)</b> view the body after death.					
23A. SIGNATURE <b>Jose S. Maisog</b> M.D.				23B. DATE SIGNED <b>10-29-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose S. Maisog</b> M.D.				23D. ADDRESS <b>Church Home &amp; Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-2-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart Cem</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>		24F. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	
24G. FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk, Md.</b>		24H. ADDRESS		24I. DATE	

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# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11479		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 11479	
1. NAME OF DECEASED (Type or Print) MR CLARENCE WARDESKA.				2. DATE AND HOUR OF DEATH OCTOBER 28, 1965   3:35 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5300 D. STREET ADDRESS (If rural, give location) 37 ADMIRAL BOULEVARD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 10/27/93	9. AGE (In years last birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEELWORKER - LABORER		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEELWORKER - LABORER			10B. KIND OF BUSINESS OR INDUSTRY CITY		11. BIRTHPLACE (State or foreign country) OHIO		
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME JOHN WARDESKA.			
14. MOTHER'S MAIDEN NAME MAY CALL.				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 213-07-4299				17. INFORMANT PATIENT, ON ADMISSION			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolus				19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs				21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOsclerosis Obliterans			
22. I certify that (this hospital) attended the deceased from 10/10/65 to 10/28 1965, that (we) last saw the deceased alive on 10/28 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.		23. SIGNATURE Louis O. Olsen		24. DATE SIGNED Oct. 28, 1965		25. MEDICAL CERTIFICATION 26. DATE OF OPERATION 10/18/65, 10/19/65, 10/24/65	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		28. CONDITION FOR WHICH OPERATION WAS PERFORMED Thyroidectomy (2nd)		29. AUTOPSY? (Yes or No) Yes		30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No		33. HOW DID INJURY OCCUR? No		34. TIME OF INJURY (Month) (Day) (Year) (Hour) No	
35. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		36. DATE 10-30-65		37. NAME OF CEMETERY or CREMATORY Oak Lawn		38. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
39. DATE REC'D BY HEALTH DEPT. NOV 10 1965		40. NAME OF REGISTRAR R. E. Farkas		41. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.		42. ADDRESS	

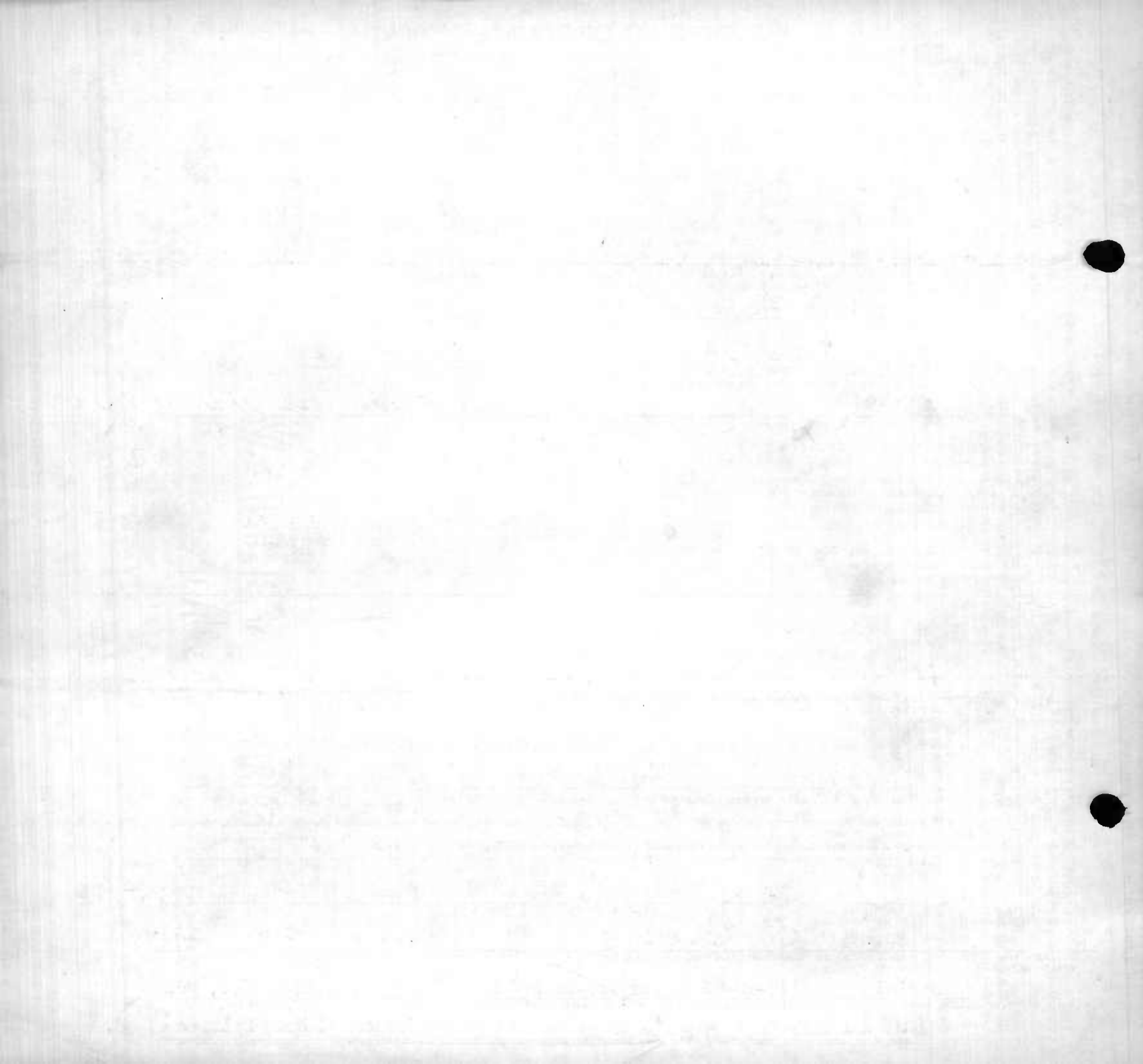




# FUNERAL DIRECTOR: IMPORTANT

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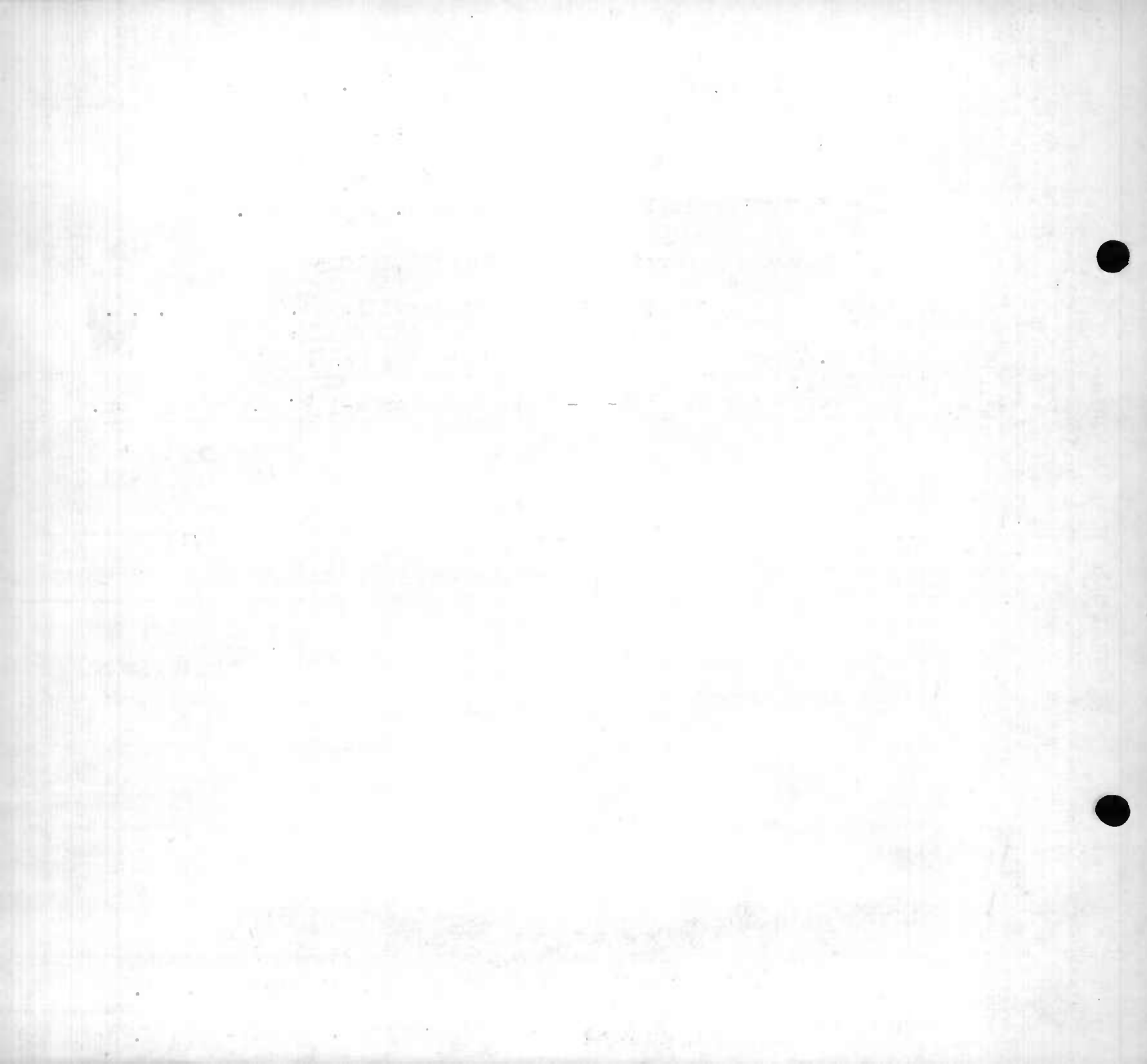
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11480</b>	
BIRTH NO. <b>65 11480</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MICHAEL SULLIVAN</b>		2. DATE AND HOUR OF DEATH <b>10/24/65 8<sup>45</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSP.</b>		A. STATE <b>MD</b> B. COUNTY <b>26-44</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>11 S. JANNEY ST.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4/2/93</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FIREMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN SULLIVAN</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE BROWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MRS. FREDA SULLIVAN 11 S JANNEY</b>	
18. <b>3005X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHU PNEUMONIA</b>		CAUSE OF DEATH (A) <b>BRONCHU PNEUMONIA</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>INTRACRANIAL NEOPLASIA</b> DUE TO <b>OR THROMBOSIS</b>		(C) <b>@ LEAST 6 MINS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>11/02/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RESPIRATORY INSUFF.</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/15</b> 19 <b>65</b> to <b>10/24</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10/24</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David J. Gillis</b> M.D.				23B. DATE SIGNED <b>10/24/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID J. GILLIS</b>				23D. ADDRESS <b>MERCY HOSP. BALTO.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-28-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>	
24D. LOCATION <b>Baltimore Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Furlong</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Ullrich Funeral Home Baltimore, Md.</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11481</b>	
BIRTH NO. <b>65 11481</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Hezekiak Jones</b>		2. DATE AND HOUR OF DEATH <b>Nov. 8, 1965</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>15-02</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1628 N. Fulton Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>June 16, 1910</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Jesterville Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Dennis F. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Conaway</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War II</b>		16. SOCIAL SECURITY NO. <b>181-09-4741</b>		17. INFORMANT ADDRESS <b>Mary Jones-1628 N. Fulton Ave.</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cardiac Vascular Disease</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>11/12/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/22/63</b> 19 to <b>11/8</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>11/8</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ralph W. Reukling</b> M.D.				23B. DATE SIGNED <b>11/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ralph W. Reukling</b> M.D.				23D. ADDRESS <b>120 N. Main St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/12/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Family Lot</b>	
24D. LOCATION (City, town, or county) (State) <b>Wicomico Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11482				BALTIMORE CITY AND COUNTY		Registered No. 65 11482	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				RICHARD ALOYSIUS SEHLHORST		11-9-65 1:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
FRANKLIN SQUARE HOSPITAL				MARYLAND			
5. SEX M				6. RACE W			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED				8. DATE OF BIRTH Dec. 29, 1901			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN				9. AGE (In years last birthday) 63			
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) County MARYLAND			
13. FATHER'S NAME FRANK SEHLHORST				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				14. MOTHER'S MAIDEN NAME Mitilda B. Trossbach			
16. SOCIAL SECURITY NO. 217 09 5532				17. INFORMANT 1742 Lamont Avenue 21202 Mrs Evelyn A. Sehlhorst			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) 1. Acute Myocardial infarction, stenosis			
19A. DATE OF OPERATION 2				(B) 2. Bronchopneumonia, congest			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				(C) 3. Pulmonary embolus, Right lower lobe			
20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct. 21 1965 to Nov. 9 1965, that (I) (we) last saw the deceased alive on 11-9-65 1:45 AM 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Wilfred H. Mediant				23B. DATE SIGNED 11-9-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11/13/65			
24C. NAME of CEMETERY or CREMATORY Glen Haven				24D. LOCATION (City, town, or county) (State) Glen Burnie Maryland			
25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965				25B. NAME OF REGISTRAR Robert E. Sander			
25C. FUNERAL DIRECTOR ADDRESS				25D. FUNERAL DIRECTOR Henry Sander & Sons Inc. Baltimore Maryland 21213			

① *Ant. nigriventris* (Forsk.)  
② *Proctos. nigriventris* (Forsk.)  
③ *Proctos. nigriventris* (Forsk.)

204

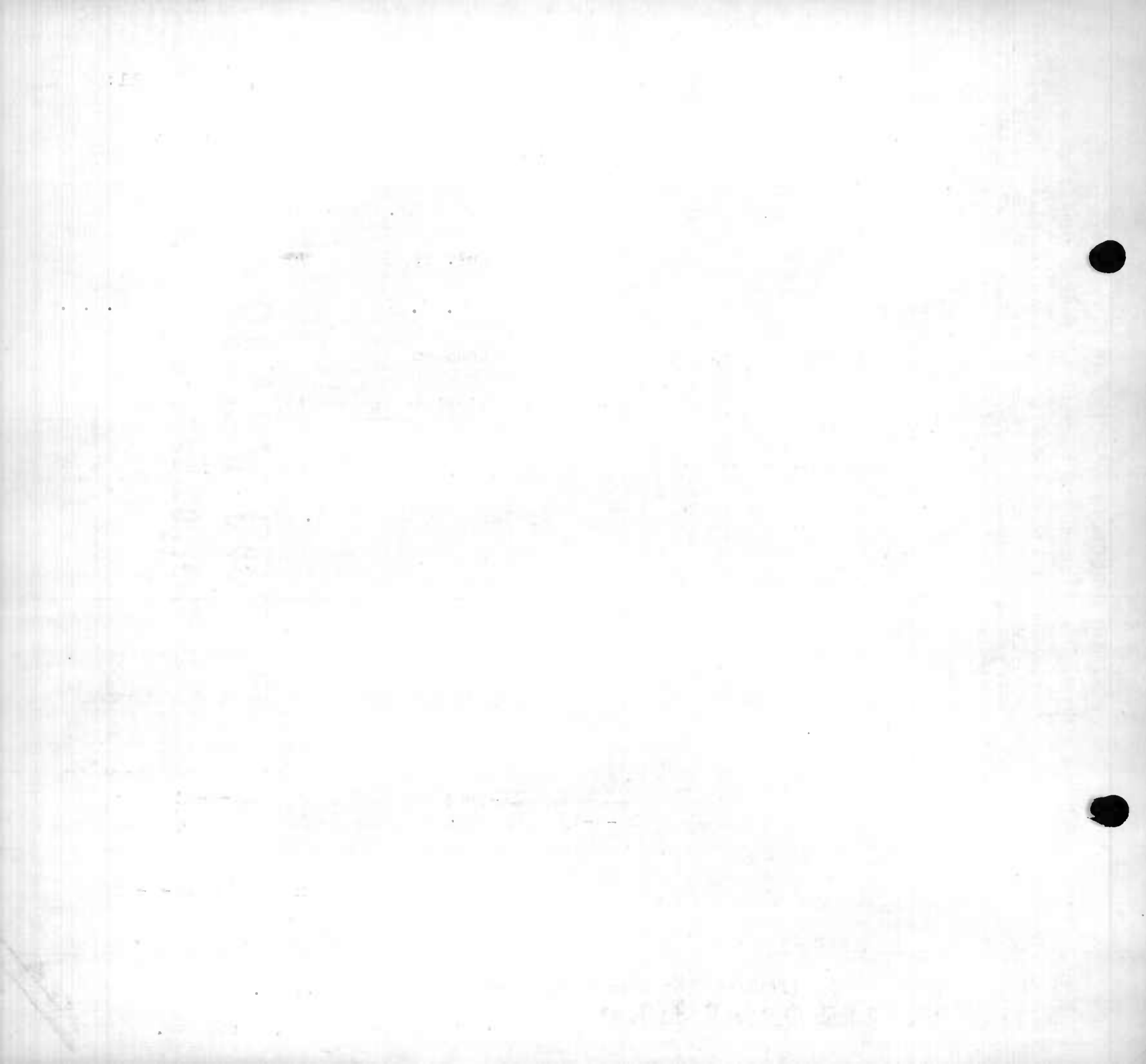
205



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 11483		BALTIMORE CITY HEALTH DEPARTMENT		65 11483	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Edward Tanner		November 8, 1965   11:50 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		13-02	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Provident Hospital 1514 Division Street Baltimore, Maryland		Baltimore		D. STREET ADDRESS (If rural, give location)	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male	Negro	Married		8. DATE OF BIRTH	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Laborer		N. C.		43	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edward Tanner Sr		Unknown		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
245-26-5151		Virginia Thomas		430 E 22 1/2 Street	
18. 600.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Marked bilateral hydronephrosis DUE TO			
ANTECEDENT CAUSES		(B) Pyelonephritis of rt. kidney DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Pulmonary edema			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11-7-65 19 to 11-8-65 19 that (I) (we) last saw the deceased alive on 11-8-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Roger Theodore		1514 Division Street		11-9-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Burial		11/12/65		Mt Auburn Cemetery	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/12/65		Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State)		25A. DATE DECIDED BY HEALTH DEPT.		25B. NAME of REGISTRAR	
Balto., Md.		NOV 10 1965		Wm C March	
25C. FUNERAL DIRECTOR ADDRESS				928 E. North Ave.	



65 11484

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11484

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GRAFTON NIGHTINGALE

2. DATE AND HOUR PRONOUNCED DEAD

11-6-65

7:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Md.

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

1081 W. Fayette St.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

May 1907

9. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTH PLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Nightingale

14. MOTHER'S MAIDEN NAME

Maggie E. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Jeanette Nightingale

ADDRESS

Rt 2  
Glen Burnie

18. E 902.10

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1081 W. Fayette St.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

11-6-65

6:45 P.m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

the laundry

Apparently fell from roof while getting

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-7-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-11-1965

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cent

23D. LOCATION (City, town, or county) (State)

Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.

NOV 10 1965

24B. NAME OF REGISTRAR

Robert E. Fairley

24C. FUNERAL DIRECTOR

Choy C. Wilson 1001 Brantley

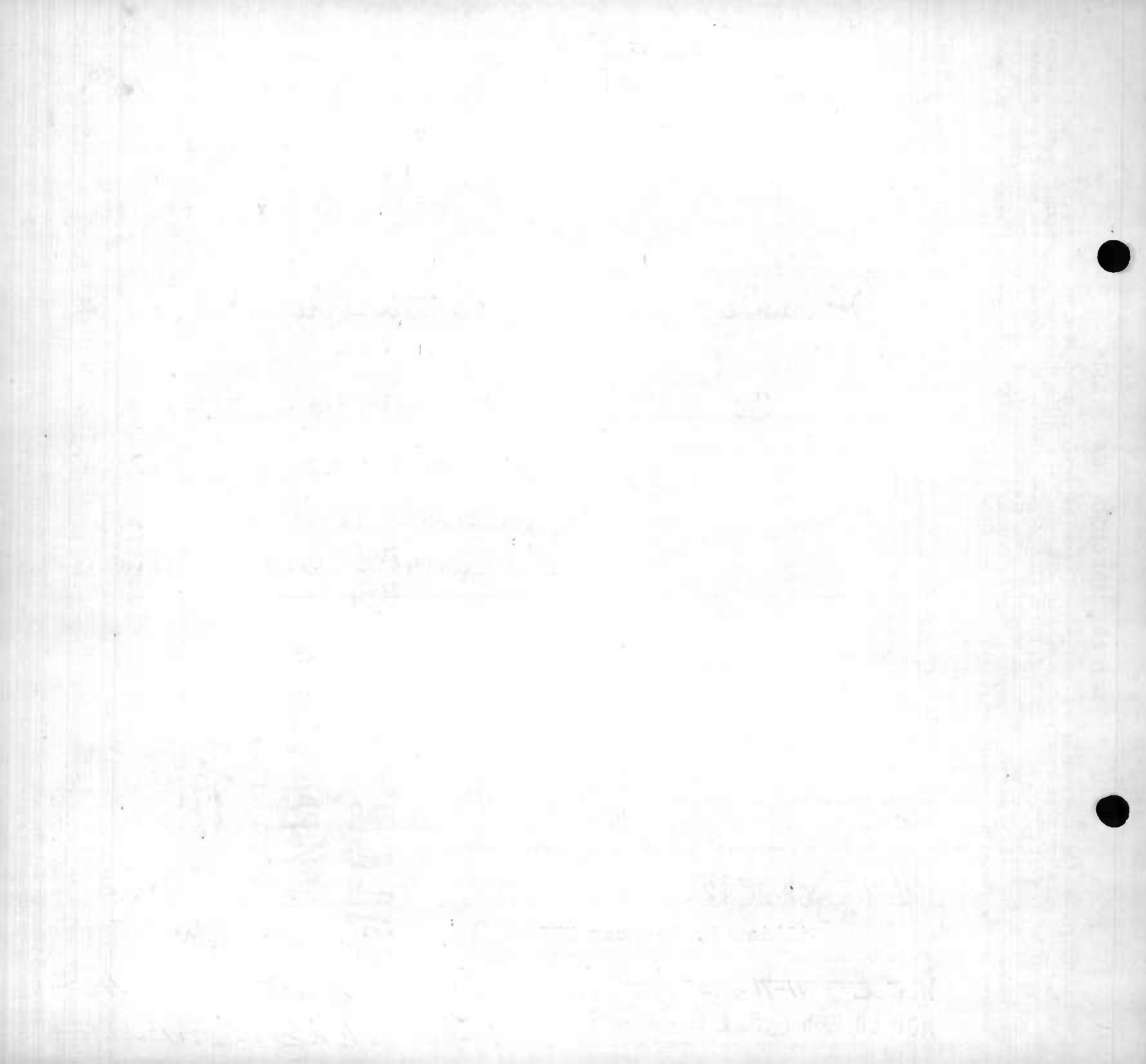
ADDRESS

WALLLEY FORCE  
STAG SCOUTS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11485				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11485	
M.E. CASE NO. AYDLETT				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Hilda AYDLETT</b>				2. DATE AND HOUR OF DEATH <b>11/7/65 1045 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
33 <b>Johns Hopkins Hospital</b>				<b>MARYLAND</b>		<b>7-04</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location)			
				<b>1011 N. BROADWAY</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOW</b>		8. DATE OF BIRTH <b>12-5-1902</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Eastern Shore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY JONES</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Moyell's Brown</b>		ADDRESS <b>3536 White Chapel Rd</b>	
18. <b>433.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <b>Caroline Arrest</b>		<b>10 mins.</b>	
ANTECEDENT CAUSES				(B) <b>Generalized Convulsion</b>		<b>5 mins.</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <b>Arteriosclerotic disease</b>		<b>30 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/3</b> 19 <b>65</b> to <b>11/7</b> 19 <b>65</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/7</b> 19 <b>65</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>W.H. Spencer III</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/7/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>William H. Spencer LLL M.D.</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-11-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Choy O. Wilson 1000 Brandywine</b>			



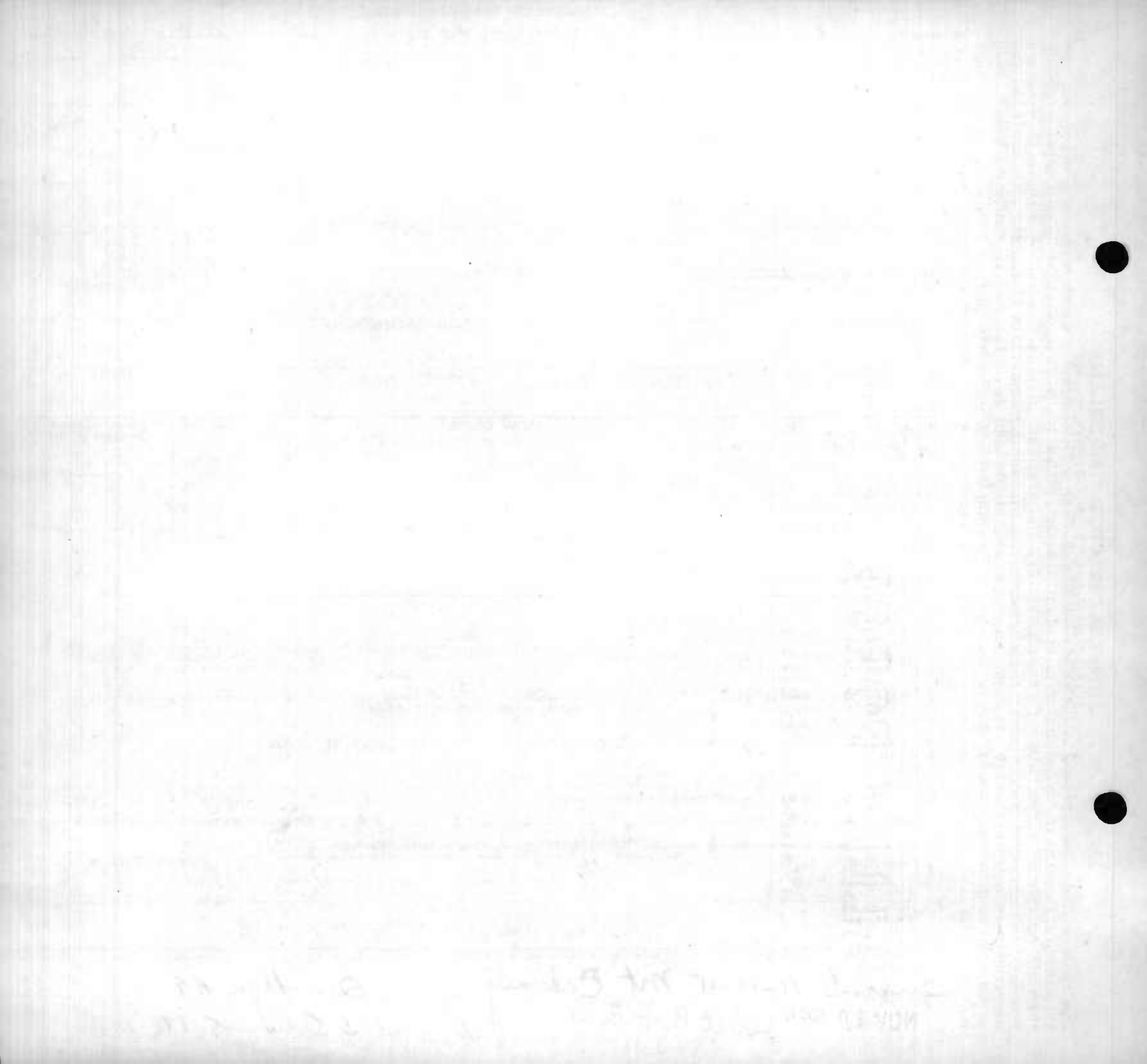


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11486		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11486	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Henson George</i>			Nov. 3, 1965 6:15 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hosp.</i>			A. STATE <i>MD.</i> B. COUNTY <i>20-01</i>		
5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			D. STREET ADDRESS (If rural, give location) <i>238 N. Fulton Ave. #23</i>		
10B. KIND OF BUSINESS OR INDUSTRY			8. DATE OF BIRTH <i>5/17/99</i> 9. AGE (In years last birthday) <i>66</i>		
13. FATHER'S NAME <i>JKE Henson</i>			11. BIRTHPLACE (State or foreign country) <i>MD.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
16. SOCIAL SECURITY NO. <i>—</i>			14. MOTHER'S MAIDEN NAME <i>Martha Brown</i>		
17. INFORMANT <i>Hilda Cousin</i>			ADDRESS <i>—</i>		
18. <i>493X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) <i>Cardiac Arrest</i> DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumonia RAL</i>			(B) DUE TO		
19A. DATE OF OPERATION <i>11/3/65</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bronchoscopy Pneumonia</i>		
20A. AUTOPSY? (Yes or No) <i>2</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>10/31/65</i> 19 to <i>11/3/65</i> 19, that (I) (we) last saw the deceased alive on <i>11/3/65 - 6:00 PM</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>P.P. Toskes</i>			23B. DATE SIGNED <i>11/3/65</i>		
23C. PHYSICIAN'S NAME (Type) <i>P.P. Toskes</i>			23D. ADDRESS <i>UNIV. Hosp.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-10-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Calvary</i>	
24D. LOCATION (City, town, or county) <i>Brooklyn AA Co</i>		(State) <i>MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 10 1965</i>	
25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>James S. Odell - Balto. MD</i>		ADDRESS	

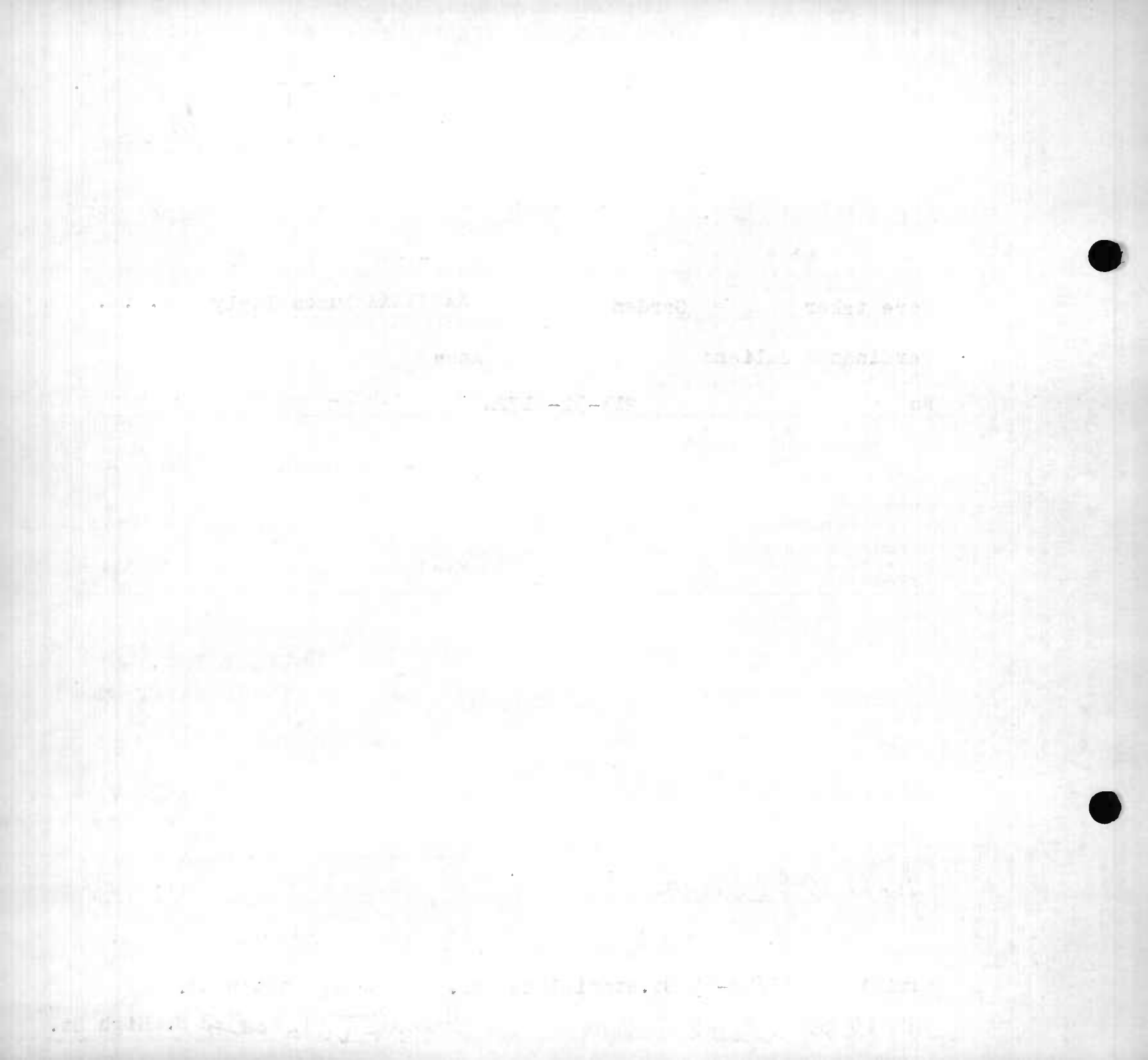




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

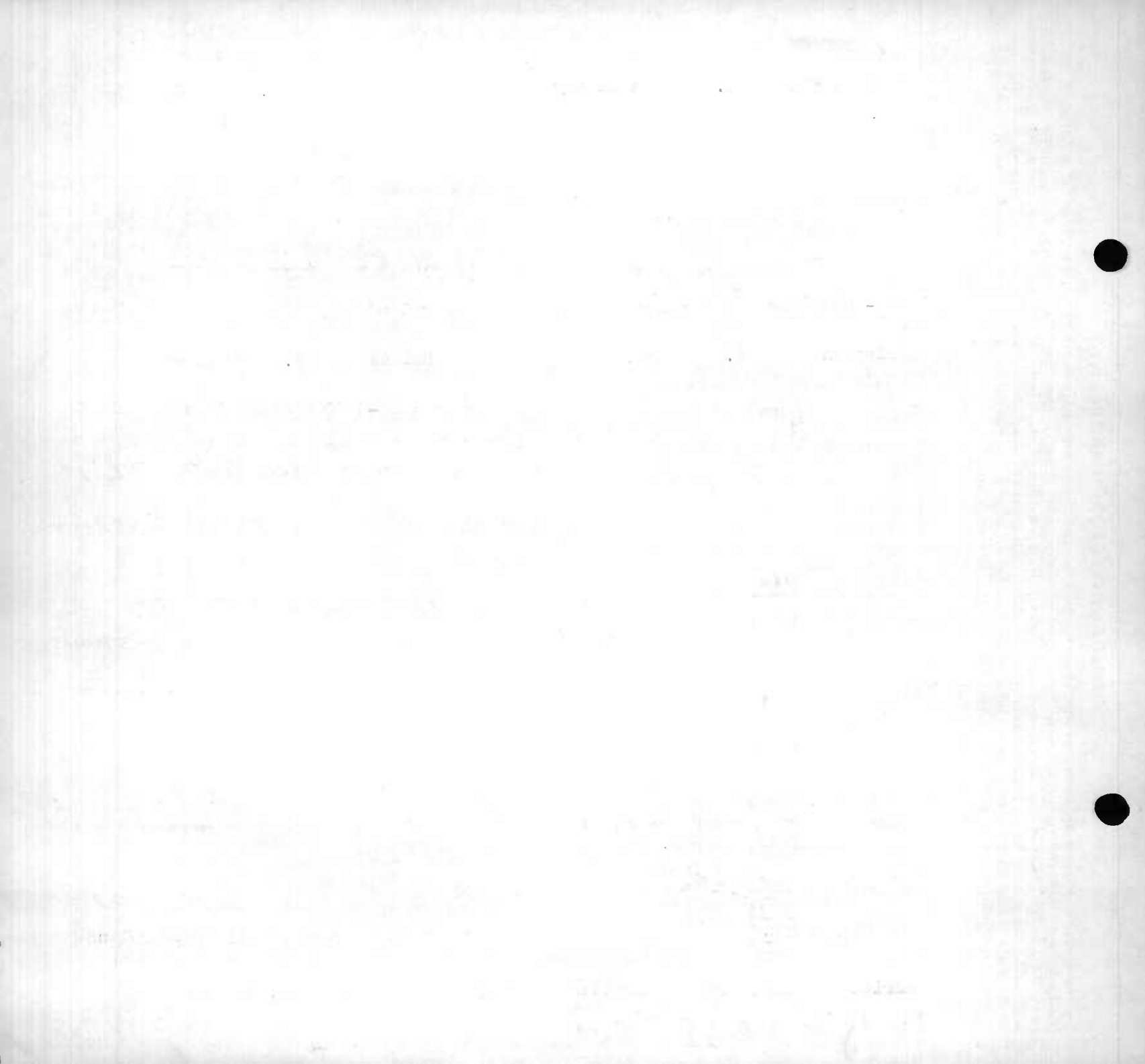
BIRTH NO. 450		65 11487		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11487	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Vincent Juliano				2. DATE AND HOUR OF DEATH 11-9-1965 6.45A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY 26-10			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 118 South Highland Avenue 21224			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-29-1872	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Care taker		10B. KIND OF BUSINESS OR INDUSTRY Garden		11. BIRTHPLACE (State or foreign country) XXXXXXXX Nusco Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ferdinando Juliano				14. MOTHER'S MAIDEN NAME Anna			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-32-6172A		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) CARDIAC Arrhythmia DUE TO (B) PNEUMONITIS DUE TO (C) Dehydration		INTERVAL BETWEEN ONSET AND DEATH MOMENT OF DEATH 3 days 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 8 1965 to Nov 9 1965, that (I) (we) lost saw the deceased alive on Nov 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leonard J. Quadracci				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/9/65	
23C. PHYSICIAN'S NAME (Type) Leonard J. Quadracci				23D. ADDRESS Maryland 4940 Eastern Avenue, Baltimore, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13-65		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cem.		24D. LOCATION (City, town, or county) 6515 Boston St. (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Frank Della Rocca		ADDRESS 322 S. High St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11488				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11488	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Katherine E. Stallings				2. DATE AND HOUR OF DEATH November 8 1965 5:35 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 103			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 638 S. Belmord Ave #24							
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 7-21-88	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Operator		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			10B. KIND OF BUSINESS OR INDUSTRY Charles Hearsey	
13. FATHER'S NAME Christian A. Koch				14. MOTHER'S MAIDEN NAME Helena E. Eilers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Idiopathic Thyrotoxicosis Abdominal aortic aneurysm				CAUSE OF DEATH A. Cerebrovascular accidents B. Cerebral Arteriosclerosis C. Due to		INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 5-10 Years 1 Yr 3-5 Years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/1/65 to 11/8/65, that (I) (we) last saw the deceased alive on 11/8/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Marc Asher				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/8/65	
23C. PHYSICIAN'S NAME (Type) Marc Asher				23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/12/1965		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE RECD BY HEALTH DEPT. NOV 10 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Wm. J. Fickman & Sons		ADDRESS Baltimore, Md. 21217	



BIRTH NO. 65 11489 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ROSIE ALSTON AKA (ROSA)</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>11-7-65</b> <b>6:05 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>100 S. Monastery Ave.</b>	
5. SEX <b>Female</b>	6. RACE <b>negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept II 1902</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <b>63</b>
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <b>John Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Susie Bacot</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Viola Garner</b>		ADDRESS <b>100 S. Monastery Av.</b>	

MEDICAL CERTIFICATION	18. <b>286.3-1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Malnutrition and dehydration</b> (A) DUE TO _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic cardiovascular disease</b>			
	19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	20A. AUTOPSY? (Yes or No) <b>no</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____
	21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
	21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
	21F. HOW DID INJURY OCCUR? _____			
	22. I certify that I held an inquiry <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
	ACTUAL SIGNATURE <b>Rudiger Breitenecker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
	EXAMINER'S NAME (Type)		DATE SIGNED <b>11-7-65</b>	
	23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>II-12-65</b>	23C. NAME OF CEMETERY or CREMATORY <b>Sansberry Cem</b>
23D. LOCATION (City, town, or county) (State) <b>Timmons ville S.C</b>		24A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>		
24B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		24C. FUNERAL DIRECTOR <b>Joseph L. Russ 672 N. Calhoun Ave</b> <b>Carrie V. Cooper</b>		

# WALLLEY BUREAU

PROPERTY CONTENT

1-1-1

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1

65 11490

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 11490

BIRTH NO. 65 11490

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HERBERT J. WEHR

2. DATE AND HOUR PRONOUNCED DEAD 11/9/65 1:20 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 5104 Belair Rd.

5. SEX male

6. RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 4, 1911

9. AGE (In years last birthday) 54

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Wehr

14. MOTHER'S MAIDEN NAME Nellie Wheeler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 215108945

17. INFORMANT Mrs. Annie M. Wehr- 5104 Belair Rd.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 11/9/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 11/12/65

23C. NAME OF CEMETERY or CREMATORY Dulaney Valley Cemetery

23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. NOV 10 1965

24B. NAME OF REGISTRAR Robert E. Farkas

24C. FUNERAL DIRECTOR Leonard J. Ruck Inc., 5305 Harford Rd.

24D. ADDRESS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

AGE

SEX

DATE

TIME

PLACE

CAUSE

MANER

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Signature

Signature

Signature

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11491		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11491	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Charles Sterling Nichols			2. DATE AND HOUR OF DEATH November 8, 1965   2:40 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalescerium			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 9-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 715 E. 37th St.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/27/1897	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Retired		10B. KIND OF BUSINESS OR INDUSTRY Crown, Cork & Seal		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Zechariah Nichols			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-09-7988		17. INFORMANT Mrs. Bertha I. Nichols
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 153.3 I CAUSE OF DEATH Carcinoma of sigmoid colon With generalized metastasis 2 1/2 yrs. INTERVAL BETWEEN ONSET AND DEATH			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 12/24/63		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of sigmoid colon		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from June 3, 1965 to November 8, 1965, that (I) ( <del>we</del> ) last saw the deceased alive on November 5, 1965 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 11/9/65	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor				23D. ADDRESS 3902 Greenmount Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/1965		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965			
25B. NAME OF REGISTRAR Robert E. Falker, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

1045

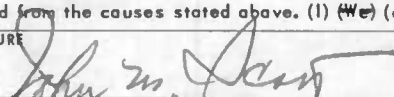
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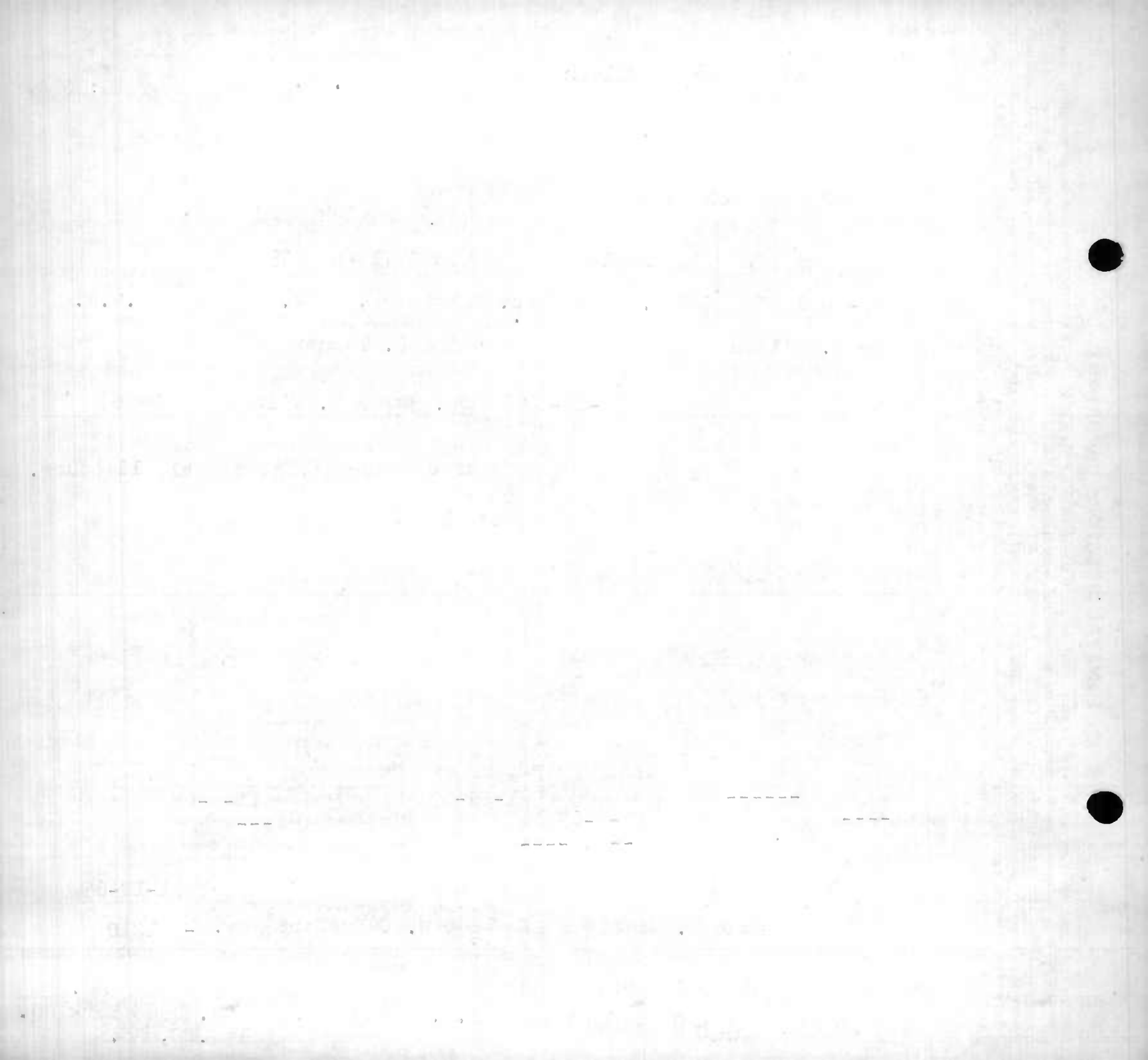
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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 11492</b>	
BIRTH NO. <b>65 11492</b>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Luther Barton Wilson</b>			2. DATE AND HOUR OF DEATH <b>Nov. 9, 1965 10:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>4825 Keswick Road</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-14</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4825 Keswick Road</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>March 29, 1886 79</b>	9. AGE (In years last birthday) <b>79</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer-Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Elec. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Luther B. Wilson</b>			14. MOTHER'S MAIDEN NAME <b>Louisa J. Turner</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-6748</b>		17. INFORMANT <b>Mrs. Sarah S. Wilson</b>	
				ADDRESS <b>(Same)</b>	
18. <b>45-1X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Ruptured aneurysm, Abdominal 12 hours.</b> DUE TO <b>Aorta</b> (B) <b>Generalized Arteriosclerosis</b> DUE TO (C)		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1-24-63</b> to <b>11-9-65</b> and that (I) ( <del>we</del> ) last saw the deceased alive on <b>11-9-65</b> and that in (my) ( <del>low</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED <b>11-10-65</b>		
23C. PHYSICIAN'S NAME (Type) <b>John M. Scott</b>			23D. ADDRESS <b>600 W. Belvedere Ave. - 21210</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/11/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount</b>	
24D. LOCATION <b>Baltimore Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1965</b>		24F. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
24G. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		24H. ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>			





RELEASED ON APPROVAL\* BY DR. HIRSCH

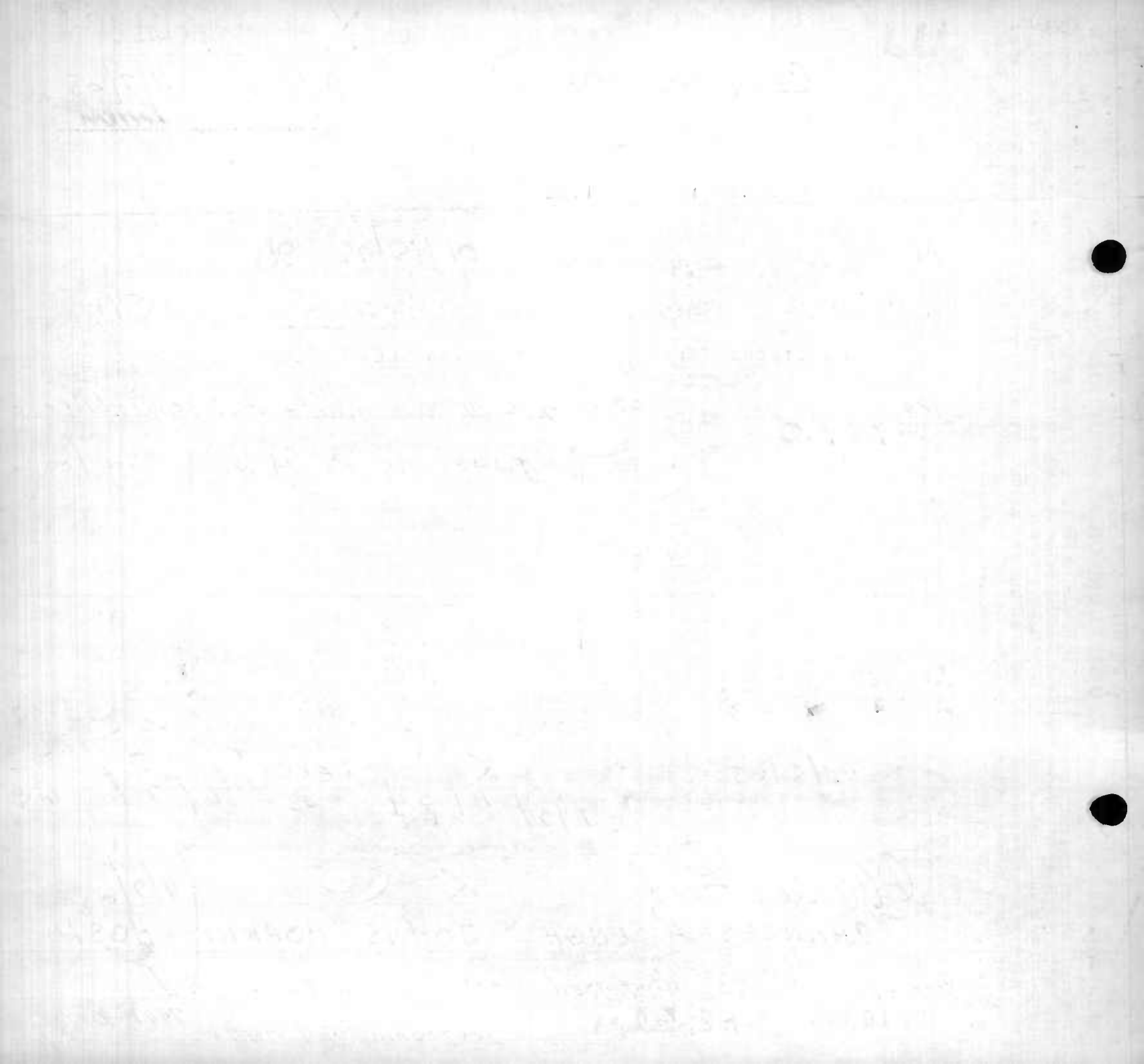
FUNERAL DIRECTOR: IMPORTANT

11-7-65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11493		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11493	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CLINTON WHITE		2. DATE AND HOUR OF DEATH 2 20 PM 11/7/65 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		A. STATE MD B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 33-00			
		D. STREET ADDRESS (If rural, give location) 6408 KENWOOD AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 01/15/75	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Wheeling Steel Co		11. BIRTHPLACE (State or foreign country) So. Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME NARCISSUS WHITE		14. MOTHER'S MAIDEN NAME ISABELLA MCCLURE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 276-0-4112		17. INFORMANT ADDRESS Anna M. White 6408 Kenwood Ave 6	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		DUE TO (A) FRACTURE RT HIP		72 hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO (B)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DUE TO (C)			
II OLD AGE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 6408 Kenwood Ave 33-00	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 11/5/65		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL trying to reach for something	
22. I certify that (I) (this hospital) attended the deceased from 11/5/65 to 11/7/65 that (I) (we) last saw the deceased alive on 11/7/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles Eng		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/7/65	
23C. PHYSICIAN'S NAME (Type) CHARLES A. ENGH M.D.		23D. ADDRESS JOHNS HOPKINS HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/10/65		24C. NAME of CEMETERY or CREMATORY Parkwood Cem	
24D. LOCATION (City, town, or county) (State) Balto Co. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965		25B. NAME OF REGISTRAR Robert E. Fink	
25C. FUNERAL DIRECTOR Lashan Fun'l Home		25D. ADDRESS 7401 Belair Rd.			





FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				BIRTH NO. 65 11494		Registered No. 65 11494	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				DUNCAN I. HASELL Jr.		11/6/65 - 1:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. AGE (In years lost birthday)	
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)				MD.		BALTIMORE	
11-17-65				C. CITY OR TOWN		(If outside city limits, write RURAL and give township)	
Sinai Hospital				BALTIMORE, MD.		D. STREET ADDRESS	
(If rural, give location)				ARMSTEAD		HOTEL	
6. SEX		7. RACE		8. MARRIED, NEVER MARRIED		9. DATE OF BIRTH	
M		W		WIDOWED, DIVORCED (specify)		11/2/02	
NEVER MARRIED		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
COPY EDITOR		NEWS AMERICAN		Charleston, S.C.		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Duncan I. Hasell Sr.		Estelle Rhett		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		Unknown		Eleanor H. Ravenel		1920 "S" St. N.W. Wash. D.C.	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) VENTRICULAR ARRHYTHMIA 15 hrs.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) CHRONIC LUNG DISEASE ?			
ANTECEDENT CAUSES				(C) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				POSSIBLE METASTASES FROM ORAL CA.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11/1/1965 to 11/6/1965, that (I) (we) last saw the deceased alive on 11/6/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.	
23A. SIGNATURE		Jerome Kemmel		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/6/65	
23C. PHYSICIAN'S NAME (Type)		Jerome Kemmel		23D. ADDRESS		Sinai Hospital Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/10/65		Magnolia Cemetery		Charleston S.C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 10 1965		Robert E. Farkas		Wm. Cook - Brooks Inc		1217 St. Paul St. Balt. Md. 21202	

5010-107-100

BIRTH NO.

65 11495

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES W. MEADOWS

2. DATE AND HOUR PRONOUNCED DEAD

11/8/65 10:46 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

13 E. Henrietta St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 4, 1938

9. AGE (in years  
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Coal Miner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Glen Daniel, W. Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hubert Meadows

14. MOTHER'S MAIDEN NAME

Macy Richmond

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

A. E. Quesenberry

ADDRESS

Beckley, W. Va.

18.

E919.0

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of chest  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

2100 Blk. Hawkins Point Rd.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11 8 65 10:00p

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot self in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/9/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

Nov. 9, 1965

23C. NAME of CEMETERY or CREMATORY

Sunset Memorial Park

23D. LOCATION

Beckley

(City, town, or county)

W. Va.

24A. DATE REC'D BY HEALTH DEPT.

NOV 10 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc. 1217 St. Paul St.

ADDRESS

WALTER Y. FORGE

W. Y. FORGE

W. Y. FORGE

W. Y. FORGE

Released & Approved by Medical Examiner  
FUNERAL DIRECTOR: IMPORTANT 11/9/65 HJ Bum MD  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11496		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11496	
M.E. CASE NO.		CERTIFICATE OF DEATH		11/8/65 9 15 P.M.	
1. NAME OF DECEASED (Type or Print)		Luther W. Johnson		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		Union Memorial Hospital		Maryland 27-01	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore		D. STREET ADDRESS (If rural, give location)	
44		4013 BIDDISON LANE			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Male		White		DIVORCED	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11/16/97		67 yrs		Usher	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Richmond, Virginia		USA		George W. Johnson	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Estelle Cotton		Yes		227-01-2296	
17. INFORMANT		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH	
Medical Records		391X1		(A) Cerebral Hemorrhage + Myocardial Infarction	
		ANTECEDENT CAUSES		(B) Atherosclerosis	
		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(C)	
		II		INTERVAL BETWEEN ONSET AND DEATH	
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		3-4 hrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		NONE		NONE	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
N/A		N/A		N/A	
22. I certify that (this hospital) attended the deceased from that (we) last saw the deceased alive on and hour and from the causes stated above. (We) (did) (did not) view the body after death.		9:15 PM 11/8/65		9:15 PM 11/8/65	
23A. SIGNATURE		23B. DATE SIGNED		11/8/65	
HARRY J. BROWN		M.D.			
23C. PHYSICIAN'S NAME (Print)		23D. ADDRESS			
HARRY J. BROWN		UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/12/65		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 10 1965		Robert E. Fidelity		1217 St. Paul St	
				Wm. Cook-Brooks Inc. Baltimore, Md. 21202	

UNION TERNAL HOSPITAL

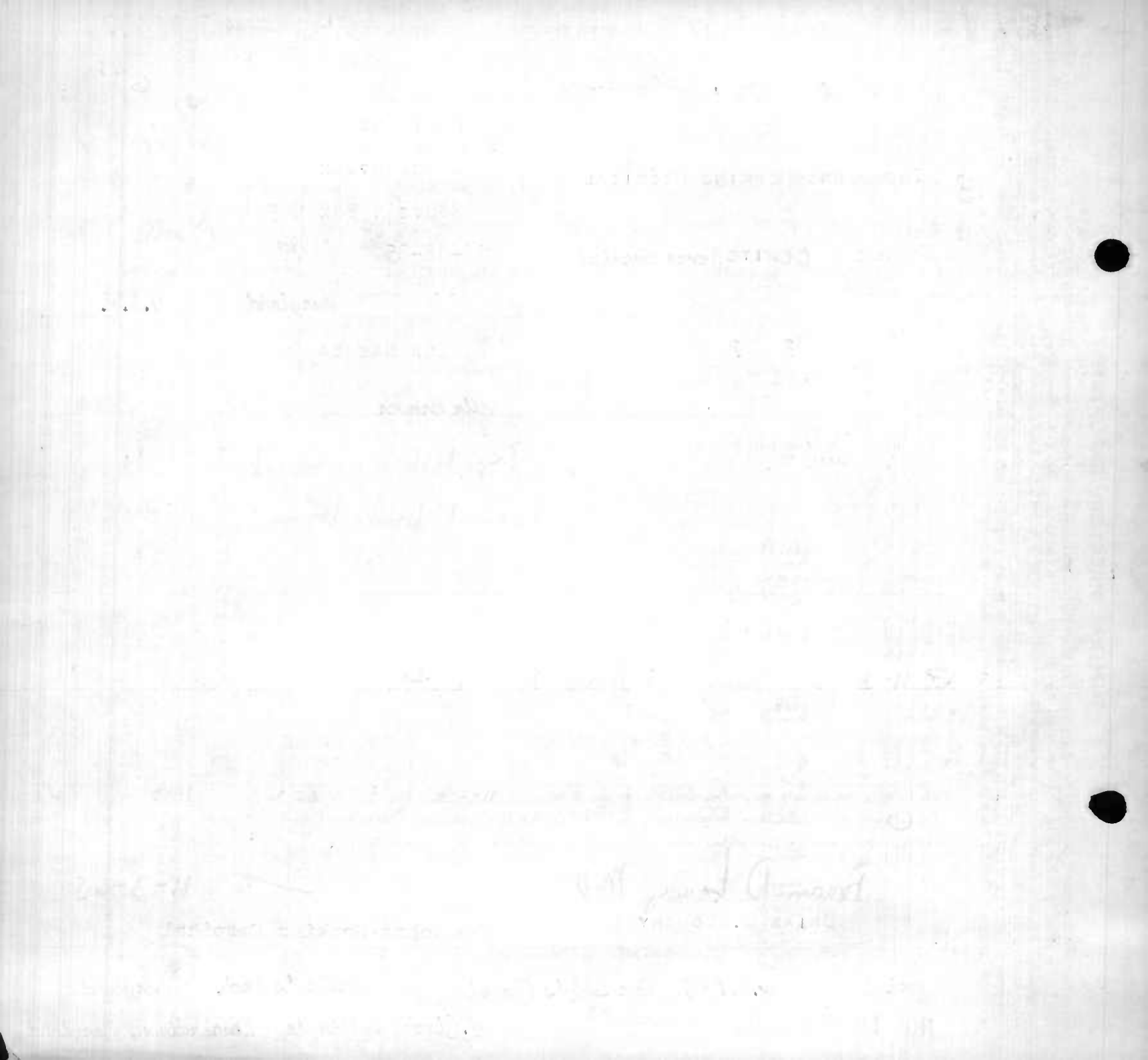
HARRY J. BROWN



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 65 11497											
CERTIFICATE OF DEATH Registered No. 65 11497											
1. NAME OF DECEASED (Type or Print) <i>Saxden, Theresa</i>						2. DATE AND HOUR OF DEATH <i>11-3-65</i> <i>6 45</i> P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>THE JOHNS HOPKINS HOSPITAL</i>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>St. Mary's</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>LEONARDTOWN</i> D. STREET ADDRESS (If rural, give location) <i>Route 1 Box 143 A</i>					
5. SEX <i>FEMALE</i>		6. RACE <i>WHITE</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i>		8. DATE OF BIRTH <i>12-12-85</i>		9. AGE (In years lost birthday) <i>79</i>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>? ?</i>						14. MOTHER'S MAIDEN NAME <i>ELLA BREWER</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ula Brewer</i>				ADDRESS	
18. <i>56111</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <i>? - probable myocardial infarction</i> DUE TO (B) <i>incarcerated femoral hernia</i> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <i>11 hours -</i> <i>30 hours -</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>11-3-65</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>incarcerated femoral hernia</i>				20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11-2-65</i> <i>11-3</i> to <i>11-3</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>11-3-65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Brian D. Lowery M.D.</i>								23B. DATE SIGNED <i>11-3-65</i>		23C. PHYSICIAN'S NAME (Type) <i>BRIAN D. LOWERY</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>Nov. 6, 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Our Lady's Chapel</i>				24D. LOCATION (City, town, or county) (State) <i>Medley's Neck, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 10 1965</i>				25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>				25C. FUNERAL DIRECTOR ADDRESS <i>W. Clarke Mattingley Leonardtown, Maryland</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 11498		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11498	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Hale Charles Walter</u>		2. DATE AND HOUR OF DEATH <u>11.7.1965</u> 12 NOON M.	
3. PLACE OF DEATH (Type or Print) <u>UNION MEMORIAL HOSPITAL BALTIMORE 18. MD</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) <u>BALTIMORE 12</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL HOSPITAL BALTIMORE 18. MD</u>		5. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 12</u>			
6. SEX <u>M</u>		7. RACE <u>W</u>		8. DATE OF BIRTH <u>1895</u> 6.12.85	
9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M.</u>		10. AGE (In years lost birthday) <u>70</u>		11. If Under 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE COUNTY</u>	
13. FATHER'S NAME <u>JOHN HALE</u>		14. MOTHER'S MAIDEN NAME <u>ENNA WOLFGANG</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-38-8448</u>		17. INFORMANT <u>MRS. <del>CHARLES</del> HALE</u> ADDRESS <u>Same as above</u>	
18. <u>163 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <u>HEMOPTYSIS GROSS</u>		<u>1 day.</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>RECURRENT CARCINOMA LUNG. AD.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>-</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>-</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>11.6.65</u> 19 to <u>11.7.1965</u> 19, that (I) (we) last saw the deceased alive on <u>11.7.65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Y. S. MURTHY</u> (Y.S. MURTHY) M.D.		23B. DATE SIGNED <u>11.7.1965</u>		23C. PHYSICIAN'S NAME (Type) <u>Y. SANYANARAYANA MURTHY</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-10-65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>FOREST BAPTIST CEMETERY</u>	
24D. LOCATION (City, town, or county) <u>PARKTON, MARYLAND</u>		24E. STATE <u>MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 10 1965</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fickens</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook Brooks</u>		25D. ADDRESS <u>1050 YORK RD TOWSON MARYLAND 21204</u>	

11-22-65

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 11499		CERTIFICATE OF DEATH		65 11499	
1. NAME OF DECEASED (Type or Print) MINNIE NEUHAUSER			2. DATE AND HOUR OF DEATH 11/6/65 5:15 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) OWINGS MILLS, MARYLAND 5300 D. STREET ADDRESS (If rural, give location) GARRISON FOREST RD. OWINGS MILLS		
5. SEX F	6. RACE W	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH 8-21-90	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Employed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SUNNYBROOK MARYLAND	
13. FATHER'S NAME ALAN HORN			14. MOTHER'S MAIDEN NAME EMELIA MEHER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HARRISON NEUHAUSER ADDRESS SAME	
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Cerebro vascular accident w/ 1 day DUE TO Subarachnoid hemorrhage (B) Hypertension DUE TO (C)		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 6, 1965 to NOV. 6, 1965, that (I) (we) last saw the deceased alive on 11-6-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gerardo M. Ypil Jr.			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/6/65
23C. PHYSICIAN'S NAME (Type) GERARDO M. YPIL JR.			23D. ADDRESS SINAI HOSPITAL BALTO. 15 MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11-9-65	24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE CEMETERY		24D. LOCATION (City, town, or county) (State) PIKESVILLE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Wm. Cook Brooks TOWSON TOWSON, MD. 21204 ADDRESS 1050 YORK RD	





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 11500		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 11500	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HUNTER, JAMES CHRISTOPHER		2. DATE AND HOUR OF DEATH 11/4/65 12:04 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		D. STREET ADDRESS (If rural, give location) 248 ROGERS FORGE RD.			
5. SEX M	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5/23/85	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY accounting V.A. RR		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES HUNTER		14. MOTHER'S MAIDEN NAME MARY SLADE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT OP ART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I 791X Branchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 11/4/65			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/31/65 to 11/4/65, that (I) (we) last saw the deceased alive on 11/4/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles E. Boring Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/4/65	
23C. PHYSICIAN'S NAME (Type) CHARLES E. BORING, JR. M.D.		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-65		24C. NAME OF CEMETERY or CREMATORY Bethel	
24D. LOCATION (City, town, or county) (State) Jarrettsville. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 10 1965		25B. NAME OF REGISTRAR Wm. Cook Brooks-Tawson	
25C. FUNERAL DIRECTOR 1650 York Rd 21204					



HUNTER, JAMES CHARLES REX 11/1/82

MARYLAND  
Baltimore

248 ROGERS FORGE RD.

2/23/82 20

MARYLAND  
MARY STAGE  
OAKT

UNION MEMORIAL HOSPITAL  
M. CAUGHRAN - M

RETIRED  
CHARLES HUNTER  
?

YES

11/1/82

11/1/82

11/1/82

11/1/82

X

Charles Hunter

UNITED MEMORIAL HOSPITAL

CHARLES HUNTER